MEDICARE AND MEDICAID FRAUDS

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

AND THE

SUBCOMMITTEE ON
HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING
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  Part 1. Washington, D.C., September 26, 1975.
  Part 2. Washington, D.C., November 13, 1975.
  Part 3. Washington, D.C., December 5, 1975.
  Part 4. Washington, D.C., February 16, 1976.

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MEDICARE AND MEDICAID FRAUDS

SEPTEMBER 26, 1975

U.S. Senate,
Subcommittee on Long-Term Care and the
Subcommittee on Health of the Elderly
of the Special Committee on Aging,
Washington, D.C.

The subcommittees met, pursuant to notice, at 9:30 a.m., in room 6202, Dirksen Senate Office Building, Hon. Frank E. Moss presiding.

Present: Senators Moss, Muskie, Clark, Fong, and Percy.

Also present: William E. Oriol, staff director; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Margaret Fayé and Gerald Yee, minority professional staff members; Patricia G. Oriol, chief clerk; Eugene Cummings, printing assistant; and Dona Daniel, assistant clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS

Senator Moss. The hearing will come to order.

I am pleased to be here this morning at this joint hearing by my Subcommittee on Long-Term Care and Senator Muskie's Subcommittee on Health of the Elderly. We meet to examine the important subject of medicare and medicaid fraud.

My personal interest in this topic stems from many years of investigating nursing home abuses. Invariably, our inquiries would yield a wealth of leads with respect to other providers, which in the past we turned over to local law officials. However, our recent hearings in New York revealed the detail and dimensions of abuse in government health programs to a degree we could not have imagined.

For example, one audit found a nursing home owner charging the State of New York for the following:

Salary for a first wife—while the owner was living in Florida with a second spouse.

Domestic help or maid service—again, for his Florida home.

Travel and entertainment, including trips to Europe, Hawaii, and the Far East.

Operating expenses and diesel fuel for a yacht in Florida.

Restaurant bills from New York, Florida, and the Bahamas.

In addition, we found operators who engaged in the following:

Listing wives as employees of the nursing home when no work was performed.

Making "donations" to political parties and charging them to medicaid as "legal fees."

Charging parking tickets to medicaid as "travel and entertainment expenses."

Charging the State for wine and liquor under the heading of "medical and professional fees."

Making interest-free loans or gifts to various individuals, including relatives. Such gifts also included Cadillacs and chauffeur-driven Rolls Royce automobiles.

Charging medicaid for tuition paid to enable family members or relatives to attend college or law school.

Withholding patients' account moneys—the $25 a month welfare patients received for personal expenses.

NURSING HOMES, CLEANING FIRMS: COMMON OWNERSHIP

But perhaps the most serious abuses were in the area of contracting out various services to wholly owned subsidiaries. Instead of hiring employees to do the janitorial and maintenance work, the home would negotiate with a contract cleaning firm. The negotiation was anything but arms length in most cases. Generally, the owners of the nursing home owned the cleaning firm. By using the cleaning firm, the home could claim that its expenses and therefore its rates were higher. In New York, the more the expenses the greater the reimbursement.

In the course of examining such vendors, we encountered an increasing number of nursing homes which own their own pharmaceutical companies. This lack of arm's-length dealing makes possible a great variety of abuses from fee splitting to substitution of generic drugs for brand name drugs. In some cases, we found kickbacks were extended from pharmacists to nursing home operators as a precondition of receiving a nursing home account. Our investigation expanded to other providers, physicians, hospitals, chiropractors, and ambulance companies.

The abuses seemed to be everywhere. As someone has said, the medicaid program, in particular, is a sitting duck for the unscrupulous.

In our analysis we learned that the majority of States had not audited one nursing home provider since the medicaid program began. The Department of Health, Education, and Welfare has audited only 192 providers since 1967. According to HEW, California, Michigan, New York, and Florida are virtually the only States that have antifraud units.

In this connection the New York statistics are helpful.

RECOUPING FUNDS THROUGH AUDITS

From 1971 through December 1974. New York audited 125 of its 400 for-profit nursing homes. It recouped $8,611,300 in fraudulent or questionable payments. During this same time period New York was able to audit only 6 of its 300 nonprofit nursing homes; 2 of its 300 health clinics; 2 of its 120 home health agencies; and 1 of its 150 health related facilities.

Dr. Frederick Parker, director of the bureau of provider audit of the New York State Department of Health explained that priority was placed on for-profit nursing homes because of shortages in staff.

What is evident to me is that there has been a general neglect on the part of HEW and the States to oversee the medicaid program. A few States have done an excellent job. Michigan is one of these States. For this reason, I am particularly anxious to hear the testimony from Michigan's "fraud squad."

We need an effective and comprehensive network of checks and balances where none exist at the present time. The medicaid program is currently the easiest of Uncle Sam's programs to rip off. The chances of getting caught are miniscule.

As members of the Budget Committee, Senator Muskie and I are becoming increasingly conscious of the Nation's spending priorities. There is a need to trim the fat and to cut back nonessential Government spending. I think the place we should begin is in eliminating fraud, waste, and inefficiency.

I am looking forward to today's hearing. I hope it will give us further insight and suggest the shape of needed legislation.

Senator Muskie is unable to be here at the beginning of this hearing because of his need to be on the floor at this time. He will be here later. He did prepare an opening statement, which I will read very briefly before I call on my colleague, the Senator from Illinois, who is the ranking Republican member on the Subcommittee on Long-Term Care.

[Senator Muskie's statement follows:]

STATEMENT BY SENATOR EDMUND S. MUSKIE

Senator Muskie. I want to welcome you here this morning to this joint hearing of the Subcommittees on Health of the Elderly and Long-Term Care.

I am sorry that I cannot be present at the start of the hearing. A sudden compromise to extend oil price controls, achieved incidentally with the help of Senator Moss and the Budget Committee task force on energy, which he heads, necessitates that I play a role in the debate which is now going on on the Senate floor. I will join you as soon as I can.

Senator Moss and I have served on the Senate Special Committee on Aging for 13 years now. We share a deep and growing concern for the health and health-related problems confronting our older Americans.

In recent months, I have been increasingly concerned about reports of abuse, waste, and inefficiency in the medicare and medicaid programs. The medicaid program in particular seems to be an inviting target for those who would cheat their Government.

Medicare and medicaid costs will rise over 20 percent this year. That figure roughly equals the cost of all other components of HEW's budget.

The staff of the Special Committee on Aging, at my direction, recently conducted a preliminary inquiry into abuses in medicare and medicaid. That inquiry led to this morning's hearing.

Today's hearing raises a great many questions in my mind:

One: How widespread are these abuses?

Two: What are the most common kinds of abuses in the programs?

Three: Which providers of care in the programs present particular problems?

Four: What is HEW doing to mitigate the apparent fraud and abuse?

Five: What are the States doing to curb abuses? And what can we in Congress do?

In this time of inflation and high unemployment, we have had to cut back good Government programs and to limit the expansion of others. The choices are never easy. But I think we can all agree that the most desirable way to cut Government costs is to eliminate fraud, waste, and inefficiency.

I will be looking to our witnesses this morning to help us find answers to these questions.

Senator Moss. I am pleased to now recognize my colleague, the Senator from Illinois, Senator Percy.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator Percy. Mr. Chairman, I might start out by commenting on what has happened since our hearings on the New York nursing home scandal. At that time we had Rabbi Bernard Bergman appear before us. He exercised his constitutional rights and declined to answer our questions.

His accountant, Sam Dachowitz, also declined to answer. Since that time, Rabbi Bergman has been indicted, Samuel Dachowitz has agreed to testify against him. I would tend to think that what is happening in New York today is akin of what has happened in Illinois since we began these hearings in 1971.

We went there not to prosecute one offender, but to demonstrate that no one is above the law, that we have the right with Federal funds being used to investigate whether those funds are being properly used, and whether the State and municipal officials are properly investigating to keep the system honest and honorable.

I think our long-term interest is to see whether or not we can develop in this country a national health insurance program. If we cannot run relatively modest programs such as medicare and medicaid, if we cannot run them effectively and efficiently without them being exploited by those who would take advantage of the poor and the old and sick for their own self-interest, then I do not see how we can venture forward with more extensive programs such as national health insurance. I would just again like to thank you, Mr. Chairman, for initiating this series of hearings, ones which began really with a joint effort between the news media in Chicago and the Better Government Association.

Back in the late 1950's, I went to the Better Government Association, which was then an independent bipartisan group, essentially screening candidates for office and making a report on their qualifications. I said, I think you can serve a bigger and nobler purpose. We do not have a watchdog in the public sector. Why don't you team up with the news media, and when they find and give you a lead, you give them the first crack at it, and put investigators on it, and work with a team of investigators. The *Chicago Sun-Times*, the *Daily News*, with WBBM, CBS, et cetera, have since that time cooperated very effectively with the Better Government Association.

I became the first chairman of it, and it has been carried on in very extensive fashion, and I am delighted that Bill Recktenwald, a prominent staff member of BGA, is now a consultant to our committee for a period of 6 months.

I think we can be gratified with the dedication and perseverance of watchdog agencies in Illinois and other parts of the country and of the news media that have been so vigilant about this problem, and who have worked so effectively with us.

FOLLOWUP NECESSARY AFTER DISCLOSURES

I am troubled that these exposés and undercover investigations continue to be necessary and seem to produce such sensational results, but there is no real followup on these investigations. It is our job to make certain that the government takes advantage of the revelations and wrongdoings that have been brought to the public's attention.

I do not know how we will ever be able to make the medicaid program work so the intended beneficiaries receive quality health care services at reasonable cost to the taxpayer without the ripoffs we have seen going on and which were enunciated so clearly and with specificity by you, Chairman Moss.

Will we ever be able to eliminate the potential for fraud and abuse which seems to exist because of faulty administration or lax management at all levels of government?

We pride ourselves on our managerial skills in this country. Our labor organizations, our business enterprises, our research laboratories, our universities, are the envy of the whole world, and yet somehow in this health field, we mismanage, we bungle. If ever a people bungled in trying to perform something, in a field where we ought to be the best, and where the need is the greatest, it is here. We just seem to fall apart at the seams in trying to be able to manage and run these programs effectively. The leeches and vultures seem to move in as fast as the patients do. This has got to be cleaned up by the various associations, the dental association, the medical associations, other professional organizations, which have worked in cooperation with this committee. I would like to say, Mr. Chairman, the staff itself, in this particular project, has been directed by Val Halamandaris, who worked very closely with members of our committee staff, and my own minority staff members on the Nutrition and Human Needs Committee.

We have had to borrow help as we have gone into these programs. We worked effectively and well together, in an absolutely bipartisan spirit, and I just want to pay tribute again to you for the leadership that you have provided, and to Senator Muskie, for his own deep interest in it.

We have received, for example, GAO reports reviewing the medicaid operations in Illinois, which are an outgrowth of a particular interest I had in this area.

We have a lot of data, we have a lot of material available. New material will be brought out today, which I think can be put to very good use in finding ways to improve these programs. That is the end purpose of it. Where do we go, once we have laid on the public record this testimony, the sordid tale that we have to tell today, and that our witnesses will be telling? I think again it is testimony to the fact that our work is far from done, though we have made magnificent accomplishments in this field, in bringing about a program of improvement. But we still have a long road ahead of us.

Thank you.

Senator Moss. Thank you very much, Senator Percy. You certainly have contributed to the effectiveness of our subcommittee. The way you have devoted your time and energy to this problem is exemplary. I personally appreciate the leadership that you have shown in this matter.

We do indeed have some very interesting witnesses, and have some sordid tales to cover today, but as you so well stated, our job is to find ways to avert the kinds of frauds and ripoffs that have been practiced in the nursing home field. Obviously, it would be much broader than that, but we have to concentrate on the area that is ours, and see what is being done in the field of care of the aged.

We do thank you very much.

We have prepared statements by Senator Frank Church, and Senator Harrison A. Williams, Jr., both of whom have expressed a desire to be here, but have not been able to come, and without objection their statements will be inserted into the record at this point.

[The prepared statements of Senator Church and Senator Williams follow:]

STATEMENT BY SENATOR FRANK CHURCH

Senator Church. First I'd like to express my appreciation to the chairmen of the Subcommittee on Health of the Elderly and the Subcommittee on Long-Term Care for deciding to take joint action on the question of medicare and medicaid frauds.

I am well aware that Senators Moss and Muskie are effective advocates of constructive actions that can be taken to provide appropriate health and medical care to older Americans.

They have called for steps that would reduce the present overdependence on costly institutions, even while insisting upon high standards of treatment of those for whom there is no other course but institutionalization.

With Senator Muskie, I have introduced legislation intended to make home health care more easily obtainable under medicare; and I have been successful in advancing my proposal to provide startup money for home health services in areas where they do not now exist. Senator Moss also has been concerned about in-home services and other elements in the "continuum of care" so often mentioned as a prime need of aging and aged Americans. As chairman of the full Senate Committee on Aging, I intend to do all within my power to support and develop a more rational health care system particularly responsive to the needs of older Americans.

"Profiteers and Profligates"

But even while the committee and the Moss and Muskie subcommittees work toward that goal, it becomes more clear each day that profiteers and profligates have infiltrated medicare and medicaid to an alarming degree, causing huge drains on public funds and great harm to the people who need the help the two programs were designed to give.

I do not say that cheating and waste occur throughout medicare and medicaid, but they exist to such an extent that the very survival of both programs will soon come into question unless corrective action is taken at the earliest possible moment.

Today, the two subcommittees will deal with significant and disturbing revelations worthy of close congressional attention. I congratulate the chairmen and staff for selecting these examples for analysis, and I hope that future inquiries will help determine whether they are isolated examples or all-too-prevalent patterns of abuse.

Medicare was enacted 10 years ago this year. I remember the struggle which led to that victory. Often, when in Idaho, I talked to older persons who told me why medicare was a matter of almost prayerful urgency to them. Without it, they faced the ever-present threat of financial disaster; one hospital bill could do that to them. Gradually, younger persons also realized that they were in jeopardy, as well: as long as their parents or grandparents lived under such a cloud, their offspring also faced a similar risk.

Well, a great deal of that apprehension has disappeared since 1965. Medicare is doing a generally good job under part A (hospital care), and I am gratified by its many achievements, even though I grow increasingly more concerned over sharply rising hospital costs. In medicare part B, medical care, and in medicaid, however, there is even greater reason for concern. It is here that fraud, carelessness, and confusion have been particularly costly; and it is here that congressional attention must turn.

One final work of caution. Within recent weeks, the Congress and the rest of the Nation have been told by high officials of the present administration that Government has become entirely too big and that it must drastically be curtailed. There is no doubt in my mind that reexamination is very much called for; and there is no doubt either, that the Congress, particularly with the help of its new Office of the Budget and House and Senate Budget Committees, can make an orderly and gradual appraisal of Federal programs with an eye for remodeling and genuine economy. But there is a sharp difference between calm evaluation and shrill denunciation of entire programs and the personnel who try to make those programs work.

I know that the two subcommittees are approaching their task today in positive fashion, and I welcome their timely action.

STATEMENT BY SENATOR HARRISON A. WILLIAMS, JR.

Senator **Williams**. Today, two subcommittees of the Senate Committee on Aging continue the important mission of reviewing the usefulness of medicare and medicaid to older Americans.

As former committee chairman and as a member of the two subcommittees, I regret the necessity for hearings directed primarily at frauds and abuses within those two programs.

I wish, instead, that we could concern ourselves with proposals to make those two programs more responsive and effective in meeting the needs of the elderly. After all, medicare now pays for less than 40 percent of all health care bills paid by older Americans. And medicaid suffers from a number of deeply rooted problems, including wide variations in care provided from State to State.

Within recent weeks, I have heard very moving testimony closely related to such inadequacies in medicare and medicaid. At hearings in New Jersey at Newark and Toms River, I heard testimony on the cost of living as it affects older Americans. The witnesses covered a large number of subjects, everything from high energy costs to out-of-sight property taxes and rents. But a recurring theme in each community was the growing concern of the elderly about rising medical bills.

Ten years after enactment of medicare, there seems to be retreat in important areas of that program. We on this committee have complained persistently and bitterly about the shrinking extended care benefit under medicare. We have criticized narrow policies which keep home health services at less than 1 percent of all medicare expenditures. And we have challenged, again and again, harsh rulings which had the effect of retroactively denying benefits. And in 1974 and 1975, we resisted administration attempts to make medicare even more expensive to elderly participants than it now is.

Policy Decisions Critical for Elderly

To older persons trying to live at today's prices, these are more than remote policy matters. They are very real threats to peace of mind and even to survival. At the Newark hearing, elderly witnesses told of having to choose between prescription drugs and paying their rent or electricity bills. Toms River witnesses told of their desperate efforts to find doctors who would take medicaid patients. Two physicians described deeply rooted shortcomings in medical care resources of a county in which the percentage of older Americans approaches 20 percent, as compared to about 10 percent for the entire Nation.

Elsewhere in New Jersey, other kinds of health-related problems are surfacing. I submit for the record an article from the September 19 edition of The Record, a daily newspaper originating in Hackensack. It says that in Bergen County alone, only 9 of 182 older persons in need of nursing home care have been admitted to such facilities this year. The number on waiting lists statewide may be at least 385.

Some are waiting in $100-a-day hospital rooms; others are trying to make do in their own homes.

In other words, there are plenty of policy-related issues in medicare and medicaid to which the Congress should turn its attention in order to remodel those programs for more effective service to the elderly. There are only so many dollars to go around, and the needs of many older persons in this Nation are so acute that waste or inefficiency cannot be tolerated.

But even more intolerable and galling is the growing realization that millions and maybe billions of dollars are going not to help people in need of care but into the pockets of schemers. For them medicare and medicaid are pots of gold for the taking, replete with opportunities for manipulation and coverup.

This certainly is the case in nursing home scandals under medicaid, so much so that far-ranging investigations have begun in New York, New Jersey, and elsewhere. But the cheating isn't limited to long-term care. A more general pattern appears to be developing, and the Congress must pay heed.

Today's hearing is one expression of congressional determination to deal with abuses even while we try to develop a more rational and responsive health care system in this Nation. It is a difficult task, but one which must be done; and I congratulate the two subcommittee chairmen for this timely inquiry.

Senator Moss. We begin today with a group from Michigan, which has done a great job in uncovering and exposing frauds that occurred there, and we are going to hear from that panel now: Paul M. Allen, chief deputy director, Michigan Department of Social Services, Lansing, Mich., and he is accompanied by John Neidow, director, medicaid program integrity division, Lansing, Mich., and Donn Moffitt, supervisor, investigations section, bureau of medical assistance, Lansing, Mich.

They have been dubbed the Michigan "Fraud Squad."

We ask you gentlemen to come forward and sit at the table; we look forward to hearing your presentation.

Senator Percy. Mr. Chairman, I would also like to express appreciation of Mrs. Julia Bloch, on the Committee on Nutrition, who helped us out.

Senator Moss. Thank you.

You may proceed. It is a wet morning, but it is a good morning, and we are glad you are here.

STATEMENT OF PAUL M. ALLEN, CHIEF DEPUTY DIRECTOR, MICHIGAN DEPARTMENT OF SOCIAL SERVICES; ACCOMPANIED BY JOHN NEIDOW, DIRECTOR, MEDICAID PROGRAM INTEGRITY DIVISION, LANSING, MICH., AND DONN MOFFITT, SUPERVISOR, INVESTIGATIONS SECTION, BUREAU OF MEDICAL ASSISTANCE, LANSING, MICH.

Mr. Allen. Thank you. Good morning, Senators, ladies and gentlemen. As indicated by Senator Moss, I am Paul Allen, chief deputy director of the Michigan Department of Social Services. On my left is John Neidow, who is head of our program integrity division. On my right is Mr. Donn Moffitt. He is the actual frontline supervisor of the fraud squad, our medicaid investigation section.

The department of social services is the single State agency in Michigan responsible for administration of the State's medical assistance program.

Prior to assuming my current duties, I served for over 3 years as director of the Michigan Bureau of Medical Assistance, the agency directly involved in operations of the medicaid program. I am pleased to have the opportunity to share with you this morning Michigan's experience in curbing program abuse and fraud in its medical assistance program.

During the fiscal year ended June 30, 1975, we spent $615 million for medical services, and we made services available to some 830,000 Michigan residents under the medicaid program. This is nearly 1 out of 10 persons in our State who receive some support from the medicaid program.

Half of that $615 million is Federal money, and half of it is social security State money. About one-third of it went to nursing homes. Another third of it, roughly $200 million, went to hospitals. The balance went to a multitude of vendors, doctors, chiropractors, et cetera.

We cover pretty much the full spectrum of health care in Michigan. I think we probably are the most liberal in terms of benefits around the Nation.

Low Administrative Costs

At the same time, our administrative costs in Michigan have been held quite low, they represent 1 percent of the total benefit payments we made, a little over $6 million is our overhead cost to administer the program.

The Michigan medical assistance program was one of the first in the Nation and was established in 1966. As was the case in many States, however, we originally did not have the expertise to manage the program, it was developed in a hurry, and as a consequence, it was not too well planned.

Our original system did not provide adequate information to the State or the Federal Government in order to manage and control the program, and as Senator Percy pointed out, management is the key to this whole business.

Michigan's initial program was operated through a contractual arrangement, as with many States, with Michigan Blue Cross and Michigan Blue Shield. They basically performed the payment function; that is, paid all of the medicaid bills.

In 1969, the Michigan Department of Social Services, under the direction of the executive and legislative branches of Michigan government, initiated a project to design and implement an improved medicaid management program. Evaluation conducted in conjunction with this project indicated that substantial savings in administrative costs could be realized from assigning fiscal agent function to the State itself. As such, it was decided that the State would, in fact, act as its own fiscal agent and the development of a modernized State medicaid system under the direction of the Michigan Bureau of Medical Assistance was begun. Implementation of the system and concurrent phaseout of Michigan Blue Cross/Blue Shield began in April 1972 and was completed in March 1973.

In effect, it was a system replete with all kinds of audits, so we can manage the program more effectively, and know where our dollars are going. As indicated, once we developed the system, we decided the State should act as its own fiscal agent, and consequently we took over the function from Michigan Blue Cross and Michigan Blue Shield in 1972 and 1973.

Our new system is the largest in the Nation, run by a government staff.

The new system was introduced over an 11-month timespan because we involved the legislature, our executive branch, and various societies representing the medical profession.

The acceptance of the new program by health care professionals, in particular, resulted in increased enrollment in the program. About 90 percent of the doctors are enrolled in the program now, and I would say all but one or 2 nursing homes out of 480 are enrolled. Most of the pharmacists are enrolled, as are all of the hospitals.

Promptness in Paying Bills Promotes Cooperation

The key to our cooperation with the medical profession, of course, is basically we pay bills very fast and equitably.

We pay very fast, and as an example, last year we processed 29 million claims in 1 year, and we paid 83 percent of them within 15 days, and the balance we paid within, pretty much within, 30 days.

Such rapid and effective payment saves many problems. For example, factoring of bills which is practically nonexistent in Michigan.

Senator Moss. By factoring?

Mr. Allen. Factoring is another term for discounting the bills for credit. We do not have this problem at all, and I know it is a problem elsewhere.

The major thrust of our new system, as I indicated, was to give us better financial management and control over the system. This we have achieved.

Meanwhile, we have raised the payment level so we pay better. The new system is giving us a lot of information, not just how many bills we pay, and how fast we pay them, but it tells us who is getting the service, and who is providing the service, and that kind of information is really necessary if you are going to manage something this big. Nevertheless, with $600 million in the pot, there is an awful lot of interest in medicaid by those who might intend to fraud, or abuse, the program.

Consequently, we cannot stop abuses and fraud, but we at least have been able to identify it, and that is why we are here to talk to you this morning.

Through the use of our information, we found it possible to pretty much identify the big volume medicaid receivers, the doctors, the nursing homes, the hospitals, that are receiving our money, and how they are getting it.

In 1971, recognizing that we had to staff up and manage this whole function, we created the division that Mr. Neidow heads up, then known as the fiscal management division, and we gave it three major functional areas.

One was a third-party liability. As you know, a lot of our clients have other insurance. They also get involved in accidents, so we have a group under John, which pursues other liabilities, to try to get the insurance companies to pay the costs of an accident that we already paid for.

This is a very worthwhile program. We also have an audit group that does the auditing of nursing homes and hospitals and, finally, we have the investigation section under Mr. Moffitt, that is the fraud squad, that does the onsite investigation, primarily of ambulatory trip providers, that is the doctors, the pharmacies, the ambulances, et cetera.

The fraud investigation of nursing homes is done by the audit group in conjunction with Mr. Moffitt's operation.

The medicaid program integrity division is the new name we have just given this operation, perhaps more in tune with the local concept in day-to-day investigations. Not all of them are auditors, some are clerical persons and paramedical personnel.

A 6 to 1 Return on Monitoring

The division's third-party liability system has been operational 2 years, and has collected \$3.1 million from other insurance sources, giving us a ratio of \$6-to-\$1 return on investment for every dollar spent on salaries in the third-party liability area.

Our program goal in this area is \$2.7 million this year, and I expect their salaries will cost us about \$300,000 or \$400,000 to recover this amount.

In the area of workman's compensation, automobile, no-fault insurance, medicare, et cetera, we are pursuing collections so medicaid can get reimbursed.

We see a possible savings of up to \$13½ million from this. The potential savings from this system are even greater once we get organized. The medicaid program and integrity division also has a small regulation and review unit which pretty much interprets Federal regulations that relate to long-term care, and acts as a focal point for nursing home matters.

Finally, we brought this investigative and audit function altogether with our automated system, as a management tool that can be used to evaluate and educate our medical providers.

If we cannot prevent abuse of the program, at least we can make providers aware of the fact that they are being watched closely, and bring them to task when necessary.

As you know, a single State agency is charged with the responsibility of determining when there is a valid reason to suspect fraud and program abuse has been committed. Program abuse is a very vague term. It means different things. Outright fraud is at one end of the spectrum, that is hard to prove, and the other end is overuse of the program, and in between there are variations in this whole subject.

Our response to the charge of detecting fraud and program abuse has been to create a set of specific procedures, techniques, and operations, of investigating the bad guys in our system.

There is no precedent in State or Federal guidelines as to how to do this. It is sort of a do-it-yourself thing, and that is what we have done.

Our investigation unit conducts investigations of noninstitutional providers, doctors, pharmacists, et cetera. We analyze their billing patterns and we can look to see if we can see a pattern of care or lack of care. We find out how many examinations they give the same client during a time frame, for example.

We determine whether they are always giving a comprehensive history instead of a limited visit for a runny nose; those kinds of things.

We evaluate these data in our office based on computer printouts, and then when we detect a trend, we go on-site, to the offices, and we examine medical records or billings to see if they are overcharging us.

Based on this, we may go to the next step which is to check with the clients, the patients; that is, to see if they actually received the service. We get into more detail, when we find true difficulties, and bring the providers into our office to discuss our findings.

Now, there is a whole due process system involved here, and usually if we find a serious situation, of course, the first thing that happens—they get an attorney—meet with us, and we start discussing the findings, and we document procedures in writing.

Requests for Refund Usually Honored

When we find these situations where, let's say, every client that comes in is getting 14 lab tests; or let's say every client that comes in regardless of diagnosis is getting EKG or X-rays; and there is no further evidence they were ever used or analyzed by a doctor—when we get into these kind of situations, then we send out letters requesting refund of moneys. We ask them to change their ways.

Most times when we catch them doing this, they in fact do refund money. In that regard, as we point out, we collected several millions in the past 2 years with these techniques. Sometimes we find actual fraud, and actual fraud symptoms are hard to diagnose, because it is a very complicated issue. Anyway, our investigation, initially, is primarily fiscal in nature, but we do have a subcontract with our department of public health. The public health department has doctors, and these doctors provide the medical advice we need to complement our fiscal findings. Therefore, in coordination, we evaluate a doctor's complete practice, for example, and then in the final analysis, our fraud squad makes a determination as to whether we have found grounds for prosecution; grounds for refunding money; grounds for termination of a provider, or suspension of his billing practices. Based on this analysis and conclusions reached, we can sit down at a table with a provider and talk this thing out.

We have several units in Mr. Moffitt's group—the medical unit, the paramedical, the pharmacy, and the office service unit. The medical unit deals with matters involving doctors, clinics, chiropractors. The paramedical is assigned to such things as ambulances. The pharmacy unit—we use this to participate in the medical program. The office unit is a small group: people who do the research, get the data out of the file, much as your staff does for you.

Our people possess skills in the medically related area, ex-corpsmen, ex-policemen, ex-narcotics investigators, a pharmacist, a nurse, and then of course, as I mentioned, we do have a few doctors that provide ultimate medical advice, when we get to that point.

At this time, I would like to make the point that very few of these analytical techniques require a physician decision at the front end. We can usually tell fraud and abuse when you see it, without a doctor there, because you see a pattern: that is, the same thing over and over again.

We have a detective sergeant on our staff, we have investigators who have education in criminal justice, et cetera.

Computers Aid in Fraud Detection

We determine the unusual patterns of care, as I indicated, pretty much by using the computers. But ultimately a person has to look at it, and make some subjective judgment, and this is the time-consuming part of this whole business.

A typical case can take 6 months to investigate, particularly if there are obvious fraud indications.

In the first year of operation in our program in 1973–74, we recovered approximately $1 million in our fraud and abuse investigative efforts. In addition, we stopped payment and bad billing practices to the extent we obviated, or headed off payments of another $665,000.

The administrative costs of our operation was approximately $285,000, which is $6 return for every buck we put in, and in our second year of operation, we came up with another $1.2 million, and our unit ratio return was $5 for every dollar expended.

We expect in this fiscal year to recover over $2 million using the same techniques of abuse and fraud investigation.

This is exclusive of the nursing home area. In a nursing home area, we recovered another million over the past year, and I will talk about that later.

Senator Moss. The two are separate?

Mr. Allen. Yes, except we use the same staff when obviously you find collusion, in the pharmacy area, in the physician area, ambulances, and so on; therefore you cannot divorce the two.

If we find a pharmacy is overcharging us and the general public, we will find the same thing in a nursing home, usually more so, so we have two separate staffs, but they work on the same subjects.

Now, as I indicated earlier, a typical review process involves going over the hard data we have, sort of a desk review of information, and then we move out into the field, go to the site, look at their records, and then we start talking with clients.

If we find something serious, then we are moving into the next stage, of perhaps legal support on behalf of the provider.

We resist the use of legal implications until the last minute in-house, because we find it is not usually necessary.

Most of the providers cooperate after you have the goods on them, to the extent that we can make agreements and a settlement. We do have a hearing process, where we have the administrative law judges, to which a provider or vendor can appeal if he disagrees with our findings. He can appeal, and he can sit down before a law judge in our department.

Senator Moss. Are those State?

Mr. Allen. Yes; State, but I do not administer them directly. They are sort of a side function, but they are State law judges, and it is the final process in our State administrative review procedures.

After that, if there is still a disagreement, and they refuse to refund the money, then we go to court, but meanwhile we have probably suspended their payments, or thrown them out of the program, or both, which we have done.

MOST PARTICIPATING DOCTORS ARE "GP's"

The onsite review of doctors, the typical doctor record, doctor profile looks something like this.

The doctor is usually a general practitioner, he is not a brain surgeon or specialist of any kind, he is a GP, without a specialty, and he sees a lot of our clients, 100 a day, 500 a week. He charges us for all kinds of lab services, incident to the patient visit.

The patient may have a minor cold, and that is a diagnosis, and he will have many lab tests. In addition, the doctor will give an EKG, mainly because he has his own laboratory, and his own radiology service. Of course, that is where he is making his money. Therefore, in general, practitioners that are in trouble with us are those who have nothing particularly sophisticated about their method of practice.

In billing, you get into a very difficult area, where the doctor can say, when he bills you erroneously, that he did not know he billed you that way. It was his staff that made the bill up, and all he did was sign it. This is one of the more obvious problems we get into. The general conclusion, when you find a fellow billing you erroneously, is to say, "Why don't you just take him to court?" You cannot, because the nature of the profession, and the fact that doctors are not business managers per se. They are delivering a health service, and claim that this is their prime interest, and the paperwork they leave to somebody else. Because it is a very difficult area, we really have to be careful as we move into these things and document our findings. Consequently, we move sometimes very slowly and ponderously through the administrative procedures process, to give him his day in court.

On the other hand, we have done it very successfully over time to the tune of $7 million within the past few years.

At the present time in Michigan, we have 13,000 doctors enrolled in our program, and about 10,000 are active; that is, they actually bill us during any 1 year.

Out of that 10,000, last year 197 of them received $25 million.

Senator MOSS. What is that number again?

Mr. ALLEN. 197 doctors took $25 million out of our program last year. There are 10,000 active doctors in our program, therefore, a little less than 2 percent of the doctors took 25 percent of the dollars out of the physician account because we spent $100 million out of doctors' bills last year. From this data you can see it is a very small segment of the physician population that is getting most of the money.

Now, that immediately tells you something, you can get all of these esoteric approaches to evaluating fraud and abuse, but the key element is who is getting all of the money. Accordingly, we arrange the computer results in descending order of doctors getting the most dollars, and as these 197 spill out, we look at them very frequently.

Now, if 197 got $25 million, that means that the average payment for this group is over $100,000 a piece per year, just from medicaid.

Senator Moss. Just from medicaid?

Mr. Allen. Yes; in addition, they have medicare, and they have their private practice, and some of them are on staff in hospitals, and so forth.

We had one doctor that got $457,000 from us last year, all by himself. Now, we are getting some of that back from him.

Senator Moss. I hope so.

Mr. Allen. Yes; a considerable amount.

Fraud Difficult To Prove

Well, he and his four associates took about $1.8 million, something like that, so far they have repaid us $462,000 of it, and we have got a claim against them for another $300,000 or $400,000, so we are getting it back, and meanwhile, we are still having trouble proving fraud.

In the area of doctors, and I already described what they do. There are also those inclined to abuse the program in the area of pharmacy services. We find that a lot of people who abuse the program in the pharmacy area report inaccurate acquisition costs, and charge us a higher cost than they paid for the drug, and then they add their dispensing fee to the bill and we pay it. We find these excessive charges by onsite audit and initiate recoveries.

There are some pharmacies who do prescription splitting, particularly in long-care settings. Many of your long-term nursing patients have a chronic illness; therefore you get continuing prescriptions. These prescriptions are issued every 10 days, even though the same prescription may be filled for a year. This way the pharmacist can get an extra fee from us every time he writes a prescription. However, our rule is that a drug should be prescribed on a continuing basis, for a chronic condition, once every 30 days to a nursing home client. By billing us as frequently as they can, this rule is bypassed.

Another abuse is to bill us for proprietary drugs prescribed by the physician, and the pharmacist actually gives the client a generic substitution. We have cases replete with that approach to abuse and we have bankrupted and forced out of business a couple of firms caught doing this in the nursing home setting.

In the laboratory area, we find the biggest problem in the laboratories, the laboratories bill us for services that the doctors never requested, the doctor requested one test, and the laboratory will do five or six, and use the doctor's name and send the bills in.

They also have a tendency to bill us for manual performance of a lab test, which is somewhat more expensive that semiautomated tests, and so we will pay the higher rate until we go in and investigate, and find they did it with machines, and they should have charged us 65 cents instead of $4.

In the nursing home area, we find the same thing you already mentioned, overuse of unnecessary ancillary services, like physical therapy, podiatry, those kinds of things. For example, a dentist will come in and examine all patients in a nursing home.

We found abuse of the patient's trust fund, we found abuse of the patients pay amount; that is, those that have pensions that may be coming in. As I mentioned earlier, we got back over $1 million last year from the nursing home area, and there is more to come.

The foregoing is a synopsis of the prepared statement I have, which was furnished the committee, along with this booklet* here of various cases that we felt would be worthy of your interest. We have taken the names off the cases furnished so we do not identify who the providers are. I did want to mention that since the 1st of January, for the first time in the State of Michigan—I think the first time anywhere—we have terminated or put out of our program eight vendors. They are no longer able to bill medicaid, and we will not pay them, and they are just out of business. They are not in jail either.

In addition, we suspended another 35 vendors for abuse. Some have asked: "What is the precedent for this? How can you do this?"

Well, we feel this is a mutual agreement between a doctor, a pharmacy and the State, to provide a service, and get paid for it under medicaid, and to do it within the prescribed Federal and State rules; therefore, if they are violating those rules, then we will terminate this mutual agreement, and drop the people from the program.

COURT UPHOLDS ACTION

So far we have been challenged in court twice I believe it was, on withholding funds. In both cases the court upheld us, that we could withhold funds, when we had abuse or fraud evidence, until we went through the whole administrative review process, and made a determination.

We had situations where one doctor took us all the way to the mat, in terms of denying he had abused the program. Yet, when it came to the point of going to court or accepting our findings, he wrote out a check for $100,000. We have had all kinds of variations on this theme. Because there really are not too many guidelines on how to handle the processing of provider abuse we have done much of our work on our own.

Senator Moss. It is indeed innovative, and this is the reason we are so glad to have you come and give us some of your experience. As my colleague, Senator Muskie, pointed out in his opening remarks, we have been talking about an even wider health care system in this country, but if we do not know how to manage it, we better not go into any wider health care system than we now have. What you are doing on this medicaid and medicare fraud is very illuminating for us.

I have the book you filed here, where you have some of the case histories. I wonder if there might be two or three of these that you might review quickly for me. I have one under tab E** there.

Mr. ALLEN. OK. That was a large firm, a pharmacy firm, that supplied nursing homes with drugs.

We investigated them because of possible overcharges, and also because of the large volume.

They received an awful lot of money from our program. We did a claims review, an extensive one. The last time this outfit apparently had been reviewed was back in 1971, by Blue Shield, and they did not find much from a limited sample.

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*See appendix 1, p. 85.
**See p. 93.

We went back in 1973, and found many bad procedures. We found them charging, as I mentioned earlier, inaccurate acquisition costs. They charged us 2 cents for a pill, and they actually got a 30-percent discount when they bought it in great carloads, and they should have charged us less than 2 cents per pill. We found they were billing us for items that were not covered in our system, but had allegedly, or supposedly been prescribed by a doctor. Subsequent onsite review could not substantiate that the doctor had ever prescribed the drug at all, and without this record, the client was being overcharged for a drug that probably was never dispensed.

There was split billing of prescriptions involved there also; that is, writing three or four prescriptions per month for the same drug for a chronic condition. We suspended payment, and we went in and looked at the nursing homes that were being supported, some 28, that were being supported by this pharmacy. The pharmacy denied using generics in these homes, and we found generics in every home we went to in varying degrees. This finding shot down all of the claims that they were not using generics. However, they were charging us a proprietory fee.

Finally, after much in-house administration work, we got together with their lawyer, and told him that there was no longer any chance of them staying in the program, so we were going to terminate their enrollment, but they did owe us money.

The net result of all of this was that they did go out of business and they paid us $120,000 to settle their account.

Cooperation Necessary for Program Review

It was a very touchy issue, and was sort of a precedent. At this point I would like to state, in this whole area, you do not want to condemn the whole profession with a few bad guys. You do have to get the profession's cooperation if you are going to do program review effectively. This case was one of our first big tests between nursing homes and pharmacists. We had found something we really wanted to pursue to the end, and we did not want to get dissuaded by any professional intervention in terms of the associations. Therefore, we kept them apprised of our efforts all of the time we were doing our investigation. We assured them we were most conservative in our approach, we do not go out on a witch hunt and tar everybody with the same brush.

Senator Moss. I am glad to have you say this, because this subcommittee is well aware, we are accused many times of saying everything is bad with nursing homes, and that all we do is tar the whole industry. As a matter of fact, we recognize there are many very fine ones, and they are doing their very best. It is only the ones that are abusing their function that we have to pick out and find ways to require them to do good service.

We do not accuse all of the nursing homes of being bad. In fact, we laud the great majority of them, but there are bad ones and we must deal with that. What you have said about your pharmaceutical situation fits right into that, and I am glad you said it for the record.

That was an interesting one. Another one I was looking at comes under tab L.*

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*See p. 100.

Mr. NEIDOW. This was actually a small drugstore. On the surface, it appeared to be a small corner drugstore, but again the high volume was there, and interestingly behind it, one of the owners of the drugstore was the past president of one of our Michigan nursing home associations, a licensed funeral director, owned two nursing homes, owned race horses, and so he could not be bad by any means. I would like to say, in respect to the medical societies themselves in Michigan, they have been supporters of our efforts. Further, I think we should give credit to our Governor, for in the beginning when we assumed management of medicaid, he created a standing liaison committee with the medical societies in Michigan. If I may, I would like to take a minute and read from the record of a recent meeting of the medical society in Lansing. This excerpt demonstrates how the society supports our program in Michigan, and contains a recommendation.

I would like to read this document, and then ask it be placed in the record.

[The document as read follows. See also tab F, appendix 1, p. 94.]

Pharmacy.—Summary Investigation Report, case No. 41–72–2.

Case background:

(A) Reason for case initiation: This claims review was performed on the basis of a report forwarded to this unit from the invoice processing division regarding possible overcharges to the medicaid program.

(B) Previous claims review record: A previous claims review was performed on this pharmacy provider on February 18, 1971, by Michigan Blue Shield. At this time, six prescriptions were checked and found to be in good order. No problems noted.

(C) Claims review period and volumes: (1) Claims review period March 1, 1971 through December 31, 1973. (2) Volume of payment during above time period $882,217.78.

(D) Claims review: The claims review was conducted on January 15 and January 17, 1974. Over 1,500 claims were reviewed.

Claims review findings:

(A) Inaccurate acquisition cost reporting and billing for a brand name drug when a generic drug was actually dispensed to the recipient.

(B) Billing for noncovered items (for recipients residing in a long-term care facility).

(C) Prescription splitting.

Action taken:

(A) Further payment of claims were suspended.

(B) On February 12, 1974, Bureau personnel met with pharmacy personnel. At this meeting, the pharmacy stated that only 2 of the 28 nursing homes serviced by them were being supplied with generics. Before this meeting closed, the number of homes being supplied with generics increased to four. In the original investigation report the percentage of generics calculated to have been used in all 28 homes was 36.21 percent. On January 15, 1974, the owner stated to investigators that he used 60 percent generics. On January 17, 1974, he stated he used 50 percent generics. On these dates, investigators were supplied with only a small number of invoices showing generic purchases.

(C) In later conferences, the owner stated that only five generic drugs were used in four nursing homes.

(D) Investigation developed a confidential informant who advised that this pharmacy was substituting generic drugs for brand name drugs and was billing the program for brand name drugs. Further, that on one visit to the pharmacy generic drugs were hidden in trucks while investigators were in the pharmacy.

(E) On March 7 and 8, 1974, investigators entered 25 of the 28 nursing homes serviced by this pharmacy and obtained samples of 31 different generic drugs supplied to these homes. In comparing the prescription numbers for these generics with the billings submitted by this pharmacy, it was discovered that the program was billed for the brand name drugs.

(F) Investigators returned to the pharmacy and reviewed all invoices supplied to them in an effort to determine the percentage of generics purchased. Only 7.63 percent of all drugs purchased were generic with the invoices supplied.

(G) Further requests were made of the pharmacy to supply generic acquisition invoices and finally they agreed to show investigators check stubs for payment to various companies. It was revealed that they had purchased drugs from 39 sources of supply not revealed to investigators previously; many of these being generic drug manufacturers.

Further action taken: A statement of findings was compiled by investigators. The violations are as follows:

(1) Billed the medicaid program for noncovered items for recipients residing in long-term care facilities.

(2) Reported inaccurate acquisition cost.

(4) "Split" prescriptions to generate extra professional fee.

(4) Repeatedly failed to supply drug purchase records.

(5) Gave untrue statements to BuMA investigators regarding generic drugs dispensed by them.

(6) Dispensed generic drugs to medicaid recipients and billed the program for higher priced brand name drugs.

(7) Submitted improper or questionable billings to the program (service not performed by a pharmacist).

The pharmacy was given notice of termination from the program, and BuMA personnel met and negotiated a refund of $120,000, based on input from the pharmacy.

Results: The pharmacy was suspended from the program and did pay the total of $120,000 refund. Case closed.

Senator Moss. That is fine. I am glad to hear that. It confirms what we have suspected: That the majority of the practitioners want to have the law faithfully executed, whatever their duty is, and when it comes out that someone is abusing it, you have to screen it out.

Mr. Allen. They cannot oftentimes control their own profession, because the people that are abusing the program are so far outside the norm of the mainstream of doctors in the society, that peer review does not work the way it should or conceptually should.

Mr. Neidow. If I could make one more statement— with respect to that drug store, you might be interested in some of the techniques that Mr. Moffit and his staff utilized in the investigation of that drugstore.

Mr. Moffitt. Actually one of the major problems in dealing in the pharmacy area is that we have to ask a pharmacy to show us all records, and costs of the drug, so we may ascertain if they are charging us the true acquisition costs.

Pharmacies are the ones who supply these, you may have to check once or twice, you may have to check their wall stocks, as you happen to go by.

You say, why don't I see an invoice for this. Ask them if they purchased generics. They say no, we supply none. Well, what about this? Well, maybe a small percentage.

So you really have to dig. This is really the most serious problem in this area, to get them to come forward with the records.

Record Inspection Difficult

We cannot go in, and say we demand all of your records. They keep them and do not show all of them to us. It is to their advantage to not present all records.

In this case, we had information from an exemployee that generics were being supplied, and we also checked with some wholesale distributors in New York and around the Detroit area, to see if they were purchasing glasses, after they told us they were not.

We were also told that on the day we were there, that the generics were being hidden on their trucks. We came in one door, and they were taking them out the other door. So we listened to what they said, and we kept demanding records, and went to review individual patients. We hit all 24 nursing homes exactly at the same time, because the telephone calls started going once we walked in the first one.

In this procedure, we actually interview the recipients, and obtain a release from the recipient, allowing us to take a sample of their drugs. We make sure the patient is covered by the nursing home for that drug, and the drugs in question are taken out to the crime laboratory and analyzed and brought back. Using this procedure, we found 31 different generic drugs.

Senator Moss. Do you have any subpena power to get reports?

Mr. Moffitt. We do not, as a department, until you come to the administrative hearing record. However, we worked very closely with the DIU in Michigan, it is federally funded, it works out of the board of pharmacy, where I was previously employed.

We work with organizations that investigate organized crime. When we get a drug involvement with controlled substances, we usually work with them, and petition the courts many times for search warrants and subpenas. Based on our presentation to the judge, we are able to secure subpenas, and search power authorities without having them as a licensing agency, or regulatory agency ourselves.

Mr. Allen. We also shop our medicaid vendors. We issue the investigative units identification cards, we shop the providers, and we allow the system to actually be billed. We process the bill through the system, and it gets paid. This procedure establishes some of the evidence and the background for further investigation.

Mr. Moffitt. There is a major problem when you speak about fraud in this sophisticated world of law, for we are dealing with a situation, where we have the physician, and he has seven clerks who have misinformation, who are not competent, and between the billing clerks and the department, we then may have a computerized or a manual billing company, tape to tape, whatever, and then we get into our invoice processing system, the treasury paying system, and the matter of proof, when you get into a computerized situation, and we go to the State fraud statutes, so this is a tremendous situation where we have to have this whole chain of evidence to prove in a fraud situation.

You have to bring in everybody involved, in every step, including their computer company, and the key word is intent.

Many times we must accept moneys back in a refund with the statement that providers must realize that any future wrongdoing, abuse, or overutilization, if it is found, will be cause for termination from the program. This termination action is an alternative rather than to seek criminal prosecution.

PRESCRIPTIONS NEVER PRESCRIBED

Senator MOSS. In this one report, you say that in a 45-day period of time the pharmacy billed the program for 18 prescriptions for one recipient, which were never prescribed by a doctor or received by the recipient. How frequently do you find that sort of thing?

Mr. MOFFITT. There is only one case we ever found it. This is what we call an add-on. Some people would come into the store, and he would type out a prescription as a phone order, put it in the file, and bill us for it. This is the only case we found in the State of Michigan, actually a blatant fraud situation.

Mr. ALLEN. That is an exception.

Senator MOSS. Could you flip to tab L* and give me a quick summary on that one.

Mr. MOFFITT. This is a joint investigation with the department of licensing and regulations, who license optometrists in the State of Michigan. We worked very closely with that agency in particular.

They were shopped, the optometrist was shopped by the member of our staff, and members of the regulation staff.

Very simply, the optometrist was giving a cursory 12-minute exam of patients with very little documentation of findings. This analysis was referred to the State optometric board. I do not know what action the licensing board has taken; documentation was very sketchy. Further, this particular optometrist did not maintain all of the required instrumentation by the Michigan Board of Optometry.

Mr. ALLEN. I would like to make a point here about one of the common threads through all of these investigations and testimony are the lack of records. There are no standards in the medical profession, or in the paramedical professions, for maintenance of clinical records.

Our clinical record could be a name and a check, saying a person was there on a date, and that is all the record you see. One of the big problems we have had, when we get down to the nitty-gritty, was the service rendered, what is the written evidence, that a service was performed. In many cases, there is none, and some of the societies, in fact, have said there are no documentation standards. They do not teach this in medical school. A provider learns it over a period of time. This lack of records makes it very difficult for us to investigate and prove many of these cases.

Senator MOSS. I notice you have one of these cases that involves a dentist. I think it is tab M.*

Mr. ALLEN. Right; now, that was sort of a strange situation, this dentist, also named "dentist of the year" the week before in this county. He was indicted, because we found that we could prove he, in fact, billed us for services; he got paid, but he had not performed the services. So this caused quite a sensation throughout the State, and all of this publicity.

He went to court, and unfortunately, he was found not guilty, but we are still recovering the money under civil action.

Mr. NEIDOW. He was also president of the county dental society. We have a civil action pending yet in that particular case. In that situation, we also worked hand-in-hand with the Michigan Department of Public Health, and with the local county prosecutor.

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*See p. 100.

Fraudulent Billing for Dental Work

The dentist was actually billing us for an item that was covered under the medicaid program, but on examination of the client, by the regional dental consultant, and his staff, we found out that dental work was done elsewhere that was not covered under the program.

This type of situation slips by occasionally, and except for post-payment type of review, you might not discover the problem.

Mr. Allen. Tab H* is probably one that covers many aspects, that we have not touched on, that I think is prevalent.

There was a situation here where there was a doctor who had a corporation. This corporation had a total of something like 28 clinics throughout the city of Detroit and in its environs. He was a very high volume provider, and he had doctors that seemed to slide in and out of the professional corporation, quickly. These employees or corporate members would stay a couple of months, and they would then go. The volume of business was so great, we looked into this situation in depth.

In one afternoon, we shopped 8 of the 28 clinics, and we found at 7 of the sites, there were no licensed doctors. The so-called doctors in white smocks were providing drugs, giving injections, diagnosing, and treating illnesses, and we closed them up right away. Subsequently, when we went to court in the county, the charges against the non-licensed persons in these seven clinics were dropped.

The problem we found here is a manifestation of future difficulties under any national health insurance plan. Basically, the problem is, how are we going to define the role of so-called physician extenders and physician assistants. Most of the unlicensed people found treating our clients at these clinics were physician's assistants.

They have some sort of medical training, they are like corpsmen, and they did provide a service, but they were doing it without any supervision of doctors, and we were being billed at the doctor's rate. I see more and more of this happening as the demand for medical services rises.

In effect, a businessman has hired somebody to act as a surrogate doctor.

Mr. Moffitt. An interesting aspect of this setting, when they were on the scene, is that all of the physicians, and there were approximately 25 physicians employed, worked on strictly a percentage basis. They had nothing to do with the billing; they did not own any of the equipment; they came in usually on a 50–50 percentage basis; and they had no responsibility for the billing or claims therein. I also think it is indicative also of the problem that a good share of these physicians were those who had problems with their licensing boards, and most of them were not able to maintain a practice of their own.

They were either on the premises in the back room, while the physician assistant was actually working on recipients, or not on the premises at all.

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*See p. 96.

PHYSICIANS' ASSISTANTS MADE VISITS

Mr. NEIDOW. We recently found on the western side of the State, and it is probably happening elsewhere, that the physician's assistant is being used by some physicians in making actual nursing home visits. Yet the program is billed for the full cost of a physician visit.

Senator MOSS. One interesting figure, in looking at this summary of cases closed and the dollars refunded, is in tab D.* It would appear that more than half of the recovery came from osteopaths. Why is that?

Mr. ALLEN. We have observed the same phenomenon, and I cannot give you an answer. We have about 2,000 osteopaths enrolled in our program, and around 11,000 M.D.'s, but the ratio of abuse among the osteopaths was higher.

Senator MOSS. I wonder about why people take the chances of beating the system when you have been operating an effective program such as you have in Michigan, there seems to be a significant number that are willing to take the risk, play the odds that your surveillance will not find them. What more is needed?

Mr. ALLEN. Well, I think that it would help us and every other State that is trying to administer a program of this magnitude if we had more Federal guidelines, and assistance that we could hang our hat on.

CLEARER GUIDELINES NEEDED

Right now, as I mentioned before, we are in uncharted waters, everything we do is innovative, therefore, it is depressing when you find yourself standing out there alone. The associations and professional groups tend to close in on you, and because we are alone, then we lose effectiveness. So I think if anything, it is that we need more finite regulations and stipulations that we can rely on, and that the professions will recognize. They should know there are certain standards we expect them to adhere to.

Mr. MOFFITT. We are constantly being asked for the source of this or that regulation, what is your authority, give us the verse, chapter, and page, and we must come back, and appear to be very arbitrary. We are establishing rules and regulations within the guidelines of this program, but that is as far as we can go.

Mr. ALLEN. I would say our final reason for establishing rules is that we are the managers of the program, and it is incumbent upon us to see that there is control. However, it is very difficult.

Senator MOSS. It is very interesting. Senator Percy left early. We have a vote on, and I must now go vote. He will be here in a matter of 1-minute or 2. In the meantime, if Mr. Halamandaris wishes, he may want to ask some questions. If you would not mind going on, I will be right back as soon as I have cast my vote.

Mr. HALAMANDARIS [presiding]. I have enjoyed your testimony very much so far, Mr. Allen. I think you have been excellent in answering our concerns. I would like you to relate the conversation we had last night.

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*See p. 91.

As you recall, at 6 o'clock last night, you were telling me how I could become a multimillionaire, and you gave me a case not too far removed from real life. You told me it is sort of a conveyor belt system for defrauding the elderly. Why don't you tell us how that is done, and how I could get to be a multimillionaire by defrauding Uncle Sam's medicaid program.

Mr. ALLEN. I guess you could do it by setting up a medical mall, and within this mall, you could have a nursing home at one end, and you could have a laboratory in the middle, including radiology, you could also have a pharmacy in the basement. You could probably have a HMO in there also, and then an abortion clinic.

Mr. HALAMANDARIS. Why a HMO and an abortion clinic?

Mr. ALLEN. These are constant cash flow situations. The health maintenance organization guarantees good cash flow. It is a good concept, but the only ones in business in depth now outside of the Kaiser plan, are the Federal Government. We have several in Michigan, and you know what is happening in California, in some of the prepaid health plans, and so there is an opportunity in all of those areas for cashing in on government health plans.

Mr. HALAMANDARIS. And the abortion clinic, is that also very lucrative? Is that a high-cash-flow situation?

Mr. ALLEN. It has increased substantially ever since the Supreme Court decision saying that abortion is up to the individual's choice.

Mr. HALAMANDARIS. Is this conveyer belt system to defraud the elderly in existence somewhere in Michigan? Is there something that approximates it?

"CONGLOMERATE" HEALTH CARE SYSTEMS

Mr. ALLEN. There are several groups that own various facilities that I described, all in the same location. They own a clinic, they own laboratories, they own pharmacies, nursing homes, and some of them own hospitals also. They have the integrated health care system.

Mr. HALAMANDARIS. Do you find that is one of the most frequent areas of abuse in the medicare and medicaid program?

Mr. ALLEN. I think not in the State of Michigan. I read much of what is going on in New York State.

In the State of Michigan, I think we do not have the same problems for several reasons, one of which, and it is a key one, is that we have a ceiling on reimbursement. You cannot get more than x amount of dollars per day. We also have other criteria in terms of occupancy rates. You cannot have a half empty nursing home and get paid a full rate.

We also have limitations on the fees we pay the administrator, which are only accepted as cost. For example, if the administrator pays himself $50,000 a year, and our standard is $30,000, we will not recognize $50,000, so we do have some controls. If you do not have cost controls in the formula, there is a great profit potential. We are spending in this fiscal year about $210 million on nursing homes, plus the patient is contributing another $50 or $60 million, so with pharmaceuticals thrown in, and with doctors' visits thrown in, for all health care, we are spending over $300 million a year in the nursing home area on medicaid in Michigan.

Mr. Halamandaris. We found it common practice for pharmacists to have to pay a kickback, averaging 25 percent of total volume, as a precondition of securing a nursing home account.

Most of that data came from the State of California, and from the State of Illinois. I wonder if you found similar experience in Michigan. Do you have to "kick back" in order to get a nursing home account?

Mr. Moffitt. To say the least, pharmacy support in nursing homes is a competitive field in the State of Michigan. We have found on occasion, actual transfers of cars, any kind of services you can expect, actual requests for percentage kickbacks, yes.

This is not only the pharmacy provider alone serving the nursing home area, it is other providers, such as physical therapy and optometry, the whole area.

Expanding Benefits Saved Money

Mr. Allen. In that regard, we have group I and group II coverage in Michigan. Group II are the persons that have other income, they may have a pension, or some kind of funds they can contribute toward their own care in a nursing home. We give them a limited amount of medical benefits plus nursing care, and we found what was happening was that the benefits we were not providing, were being provided by other health care providers. For example, physical therapy was being charged against the other income of the patients, and we found by expanding our benefits to give physical therapy to these people, we saved money, because their income was not available for this ripoff, if you want to call it that, but was available to contribute towards their necessary day-to-day care.

We saved a couple million dollars by expanding benefits.

Mr. Halamandaris. Say that again.

Mr. Allen. We saved over $2 million by expanding benefits, because we got the money contributed from the client, instead of the client paying a health care provider for very questionable health care items.

Senator Moss [resuming chair]. That is a little unusual to say the least.

Mr. Neidow. Those funds were funneled through the department, and the department better managed the expenditures with respect to medical services, rather than leave it to the mercy of others on the outside. At times we found the nursing home proprietor, or the physical therapy company, the optometrist, or other type of practitioner went through the nursing home, wholesale, treating every patient, whether he needed it or not. Physical therapy, whatever the ancillary service might be.

Mr. Halamandaris. A few more quick questions. You mentioned in your statement that factoring is not much of a problem in Michigan, because you pay off in a hurry. In Illinois, it is a big problem, because of slow payment.

Possible Organized Crime Involvement

There is one suggestion, and some later witnesses will tell us about it, that organized crime is muscling into the nursing home ownership.

Have you seen any indication that this is involved in the State of Michigan?

Mr. Moffitt. In the nursing home area, yes.

Mr. Halamandaris. Tell me about it.

Mr. Moffitt. This is mostly documented by various agencies in and around the city of Detroit, but we have several alleged people in the area of which you are speaking who acknowledge underworld contacts themselves, and who have large holdings in our nursing home area.

Mr. Halamandaris. You say large holdings, what are you talking about?

Mr. Moffitt. Many, many nursing homes.

Mr. Halamandaris. Do you have any figures?

Mr. Moffitt. I do not have any.

Mr. Halamandaris. Any guesses?

Mr. Moffitt. No.

Mr. Halamandaris. Can you tell us whether they control nursing homes traded over the American and New York Stock Exchanges, or are we talking about limited chains, where the lines would be less apparent to the public?

Mr. Moffitt. The latter.

Mr. Halamandaris. Let me ask you about the ownership disclosure statute, the Federal statute plugging the law in 1967, apparently that is not effective in telling you who the owners of the nursing homes are. If you cannot tell us whether organized crime is involved, and to what degree, the statute must not be effective. Do you have any comment on that?

Mr. Allen. I do not think we are in a position to comment on that, Val. We have observed these connections, but we have not pursued them, as you are pursuing them now. We do know pretty much who owns homes in Michigan. I do not think there is any question about who owns the homes in Michigan. As to whether or not they have underworld connections, that is another problem.

Mr. Moffitt. They are routinely audited, to use that word.

Mr. Halamandaris. Have you made an attempt to contact the Department of Justice, and to give them the leads? It seems to me this subcommittee has tracked leads from New York, and Illinois, and now you are telling me there is some evidence at least of this kind of thing happening in Michigan.

We have leads in the State of Florida. Can't we somehow interest the Justice Department in seeing that these leads are tracked down?

Cannot you and I together go down to the Department of Justice and spend some time with the people there and suggest they conduct a wider investigation, or do you regard it is not a significant problem?

Mr. Moffitt. If we find anything of any interest, I would say we have good communication with the organized crime departments, the Department of Justice, and other organizations.

Mr. NEIDOW. Generally using local prosecutors, we have shared and exchanged information and are working cooperatively with the program, and with people of integrity at the Social Security Administration in the Chicago regional office.

We have several cases going with them jointly and their medicare intermediaries. These cases may prove worthwhile, and may end up in the U.S. Attorney's Office.

THWARTING ILLEGAL INVESTMENTS

Mr. HALAMANDARIS. I think it is an important question, because we are spending about $30 billion for medicare and medicaid. If we move forward in national health insurance, we will be talking about astronomical dollars. The people in organized crime are good businessmen. They will be looking at that as an attractive investment opportunity, unless we do something to head it off.

I think we ought to pool our resources and talk to the Department of Justice and see if we can conduct a really hardnosed investigation and follow up those leads. That really goes beyond the ability of this subcommittee to do it all, and maybe by working together, we can accomplish something.

Mr. ALLEN. You have a good point, and probably it should be pursued. We have only been at this business over 2 years. and our initial thrust is to find out whether or not we are paying for quality care, and whether we are getting our money's worth. That is probably the next step.

Mr. HALAMANDARIS. I have another question which relates to the use of the intermediary, Blue Cross/Blue Shield.

Didn't you recently change the claims processing, and take it away from Blue Cross and Blue Shield?

Mr. ALLEN. Yes; in 1972, that is when we took over the program.

Mr. HALAMANDARIS. Why was this decision made? What were the particular facts involved?

Mr. ALLEN. I guess primarily the logic goes like this, if you can do it more economically yourself, why have somebody else do it for you, since basically you are responsible for spending your money.

Medicaid is the State's money, half of the funds are, and the other half is Federal. So since we did design what we considered a good medicaid management system, an economical one, we staffed it with State personnel, and did it ourselves, and in so doing, we did save money.

Mr. HALAMANDARIS. Let us get down to some hard-nosed facts. You said in your statement, at the present time, you are only burning up 1 percent of your total medicaid payments in administrative costs. What was Blue Cross burning up for administrative costs?

Mr. ALLEN. Let me say this. We had a 30-percent reduction in annual costs of administration after we took over, and our administration was much wider in scope, because what you are seeing now is part of that cost.

We expanded the scope of management, but we reduced the cost by 30 percent.

Mr. HALAMANDARIS. On the basis of this experience, would you suggest to other States, they evaluate their use of intermediaries, particularly Blue Cross?

Balance Necessary for Proper Administration

Mr. Allen. Personally, I think all States should evaluate it, and here is a chance to express some philosophy. In the long haul, I think there has to be a balance in any national health insurance program, between the private and public sector in administration.

If you do not have balance, neither one will do the job properly. If you give it all to private industry, they will not do it right. In this kind of system, where the State is providing most of the money, then I think the State can do it and should. Given the state of the art today in processing medical management systems, so almost any State could do it well.

Mr. Halamandaris. You are bursting balloons. Blue Cross, or others, will come in here in a couple of days and tell us that they have a certain expertise you do not have. The insurance companies will say they have the expertise, the technology, and that they will do a better job.

Do you buy that?

Mr. Allen. I do not agree. Currently, I think it is very expensive for them to do it. Our unit costs today are the lowest in the Nation, and we have been audited a half dozen times to prove these are real costs.

Mr. Halamandaris. You have almost got me convinced.

What advice would you give other States that want to set up a fraud squad, such as yours. How do you do that?

Mr. Allen. First you have to have the desire, and then you have to have the guts. It does take guts. There is no body of law or procedure, and you are sort of going out in an area relatively unexplored. Nevertheless, with a very small staff, with something less than 8 or 9 people, any State could start it up. Using the available data, if it is available, and over time, say over a period of 3 or 4 years, any State could build up the expertise to make any program like this worthwhile.

Senator Moss. What recommendations would you make to other States?

Mr. Allen. Well, I think, the first thing I would do is tell the other States that they should become more familiar with the information that is being generated from the current intermediary. If they are contracting with an insurance company, as the Blues, to do their business, there is a wealth of information these people have on the program, that properly structured and assimilated, a State can benefit from.

They can find out in depth just where the money is going, and where it looks suspicious, and based on a close liaison with their intermediary, as we are, they can use this information, work with the various professions, and establish a doctrine to let the vendors know that they are being observed, and the program is being managed.

Senator Moss. You pointed out that you recovered much more than the costs of your operation. That should be an incentive to other States, should it not?

Mr. Allen. Well, it should, but sometimes the financial aspects are lost, because it is a very nervous business, and it is a high management risk, unless the management at all levels is behind it.

Mr. **Moffitt.** We are making waves on any given day we have done our job.

Senator Moss. I wondered also, when you projected how much you expected in recovery this year, if you can discern much progress, because apparently there are still people trying to beat the system.

Some Abuse Inevitable

Mr. **Allen.** I think a sufficient percentage of this group will keep after your program dollars, no matter what. You block them off here, and they will come in here, and so I think it is a constant battle, but we have seen evidence to the effect that it is getting down to the point where they are getting more sophisticated in trying to bypass the system; that is, defraud it, or abuse it.

Mr. **Neidow.** I might add that Mr. Moffitt and I are coming back at the request of HEW Medical Services Administration next Tuesday and Wednesday, to meet with HEW, and other States that are taking a step in this particular direction, so the steps are being taken, other States are intercepted, and we hope they will go forward.

It would be helpful if the Federal Government could give some encouragement in the way of 100-percent Federal funding for our postpayment review-type programs, or our third-party-type programs. This would allow more States to introduce a management system to govern in these particular areas, because we have demonstrated they more than pay for themselves.

This is a good investment.

Senator Moss. I have introduced a bill, S. 1570, to establish the Office of Inspector General in the Department of Health, Education, and Welfare, to coordinate investigations of medicare and medicaid fraud.

Do you have any comments on this proposal?

Mr. **Allen.** Well, I think we need one at a very high level, and I would like to see it to be a pragmatic one, that is a doer, and not some more overhead, because in this business, you really do not need a lot of sophisticated techniques.

The investigative nature of this business is very mundane in the criminal sense. You do not have to be a doctor to investigate it, but you do have to keep the overhead down or else it will eat up any benefits very quickly.

Senator Moss. Another of these bills, S. 1164, requires that all nursing homes participating in Federal programs file a CPA-audited cost and financial statement with their State.

Do you think that is a desirable thing?

Mr. **Allen.** Well, I think it should be done. The problem is, of course, we will wind up paying for the CPA audit because we finance 75 percent of all of the beds of all of the nursing homes in our State through the medicaid program. We have had difficulty in the State of Michigan getting good audited cost reports from the nursing homes, and it is a continuing problem, and anything of that nature would help.

Senator Moss. If there were Federal funding of the cost of conducting audits, then that would be more political, is that right?

Mr. ALLEN. Right. I am not saying that we would not be willing to pay our fair share if it is a worthwhile investment.

Senator MOSS. We found one of the most common abuses was depriving patients of their $25 a month personal spending money, and in some instances, they commingled it in their general accounts, et cetera. Have you found much evidence of this abuse?

Mr. ALLEN. Yes, we did.

LAUNDRY COSTS CHECKED

In fact, it was a very common thing, about 2 or 3 years ago in Michigan. One thing we did to head it off was to hit one of the major areas that they get the money from—personal laundry. What we did was we expanded the program to include personal laundry costs in the nursing home rate, and this way we are able to audit abuses.

Sometimes they had charges of $20 a month for the laundry. We also find them charging for electricity, and things like that, if they have TV in their room. We also find them commingling this money with the nursing home funds. We found all of those things, and it is a continuing problem.

All of the nursing homes are audited on a continuing basis.

Senator MOSS. I have been monopolizing the time. I would like my colleague from Illinois to ask any questions he may have at this time.

Senator PERCY. I just have a couple of questions, Mr. Chairman.

First, I wonder if, in the State of Michigan, it would have been possible to have had the sort of abuses that news media, the Chicago Tribune, particularly of recent date, have pointed out: assembly line tonsillectomies on medicaid families, for instance; going out, rounding up skidrow people at skidrow hotels, alcoholics, and those on drugs, and taking them in for detoxification programs, without too much of a humanitarian approach to it. Would that be really possible on any extensive scale in Michigan, with the procedures that you have now outlined to us?

Mr. ALLEN. Senator, when we were setting up our new system in Michigan, I personally went to Illinois on two separate occasions, spent several days observing the Illinois medicaid operation, and came back to Michigan, and we put ourselves in business administering medicaid in 1972 and 1973.

The difference between our system, and the Illinois system is primarily one of automation and order.

The one in Illinois was replete with tons of paper. There was paper all over the place, and paper tends to confuse the management process. You do not know what you are looking at when there is too much of it. When we put our system in, we eliminated most of the paper, and we designed the system so it would highlight the people, such as you described, who are doing again and again certain things that are abnormal, that is, those who are seeing the whole family every time they visit. The computer can help you do that.

It takes people to observe the results and to do something about it, and so in Illinois, I knew from the beginning it was not working well, because of all of this paper, the people just did not appear to know what was going on in total although they were adequately reviewing independent billings.

Senator Percy. The last question I have pertains to whether the Michigan antifraud squad deals only with medicaid, or is there coordination with the medicare program?

I ask that because the GAO report of the Illinois medicaid program recommended a consolidated fraud and abuse unit for both medicare and medicaid at the professional level, because providers worked with both programs.

Would you agree with the GAO recommendation, and if so, how best can the Federal Government help support States' efforts to curb abuse in medicaid and medicare?

Cooperation Should Be Improved

Mr. Allen. I would answer it this way. I think we do not cooperate as much as we can, or should, with medicare in the State of Michigan. We should do more than we do. We have not, primarily, because medicare does not do much in the State of Michigan, and so we felt if we tried to get too close to them, we would bog down their own effort or our own effort, if you understand what I am saying.

The other aspect, if you had a joint investigative group of medicaid and medicare going under some State structured management processes versus a total Federal system, which the medicare system is, I think this would tend to be a degradation of the individual State's efforts, and there would probably be a submersion of the overall effort. I think it would get too big, and get oriented toward Baltimore more than toward Lansing.

Senator Moss. We would like to welcome Senator Muskie. I would like to say, Senator Muskie, I think you worked out a good compromise on the oil situation, and we can move forward on that. I would like to say also that I read your statement this morning with enthusiasm, vigor, and interest, and you could not have done it better.

Senator Muskie. I thank you very much.

Senator Moss. Before I turn to Senator Muskie, I think John Guy Miller, minority staff director, has a question.

Mr. Miller. Before Senator Fong had to leave the hearing, he read your prepared statement carefully and followed your oral testimony with intense interest. He asked me to pose a line of questioning on his behalf. Senator Fong's question line essentially boils down to a single question. How is all of this information about the nature of the fraud and abuse problem, as revealed in your work in Michigan, and—more importantly—your techniques in its control, being disseminated nationally?

You made reference to a meting in the next week or so being sponsored by the Department of Health, Education, and Welfare to do this. Senator Fong is very much concerned about whether there is an ongoing national mechanism for distribution of this kind of information to other jurisdictions.

Can you tell us something about this?

Mr. Allen. It started off this way. Our first exposure was in our region 5, which is Minnesota, Wisconsin, Illinois, Michigan, Ohio, and

Indiana. We conducted a seminar in Lansing for all of those States, to show them what we were doing, and to give them some concrete ideas on how they might do the same thing.

Subsequently, we made a presentation in Washington and we participated for a week in a HEW seminar of all the medicaid directors in the spring. That was the next largest exposure.

Recently, HEW established this new office, I believe you authorized funding up to 108 persons, and so they have been out to visit us, including the new acting director of this group. Further, next week, Mr. Neidow is participating in another HEW seminar. If we can bring this body of knowledge together, and promulgate it to everybody, that will be one significant step.

Mr. MILLER. Then it is fair to say the Federal Government is actively involved in meeting the problem?

Mr. ALLEN. Yes.

REVIEW OF FIELD AUDIT PLAN

Mr. NEIDOW. I would like to comment further. The Federal people, with two subcontractors, came to our State in the last couple of months. I also understand they have been to California and New York to discuss the antifraud program. The topic we are discussing next week here in Washington is a review and critique of a national field audit plan for pharmacies, nursing homes, and physicians. Later meetings are planned as a followup.

Mr. MILLER. It is obvious from Senator Fong's interest in this question that he was very much impressed with the fine work done in Michigan, and that he recognizes the importance of this kind of information, and of extending it to others.

Senator MOSS. Thank you.

Senator Muskie did not have an opportunity to hear your statement, but he may have a question or two.

Senator MUSKIE. I would like to say we all appreciate the contribution that the State of Michigan has been making to the development of surveillance approaches to this problem.

I have just two general questions, which I am told have not been covered, that might be helpful to us. First, what kind of guidance and direction have you been given by HEW, if any, to carry out the abuse and fraud detection?

Mr. ALLEN. Well, other than the basic law and the HEW regulations on establishing some management unit to ensure that we are paying bills properly, and receiving the services as billed, there are none. Existing guidelines are very vague, and as I mentioned a little earlier, Senator, that is what most of the States need.

They need a little more support and guidance. Because right now, if they do this sort of thing, it is on their own, and when they get out there, and the Federal Government is not behind them, they are in great difficulty with the medical profession.

Senator MUSKIE. This, in your judgment, reflects a lack of concern in HEW about this problem?

Mr. ALLEN. I think it is a concern with more important things, perhaps.

Senator MUSKIE. So you can stand a little prodding, and a little support?

Mr. ALLEN. Yes.

Senator MUSKIE. What further can the Federal Government do in your judgment to encourage this kind of fraud and surveillance system?

LANGUAGE SHOULD BE CLEAR

Mr. ALLEN. Well, I think, I alluded to it a moment ago in answer to Senator Fong's question. They could help us by establishing sort of a code of ethics, or a code of procedures, and in English.

Senator MUSKIE. In English?

Mr. ALLEN. In English. Right now it is difficult to understand some of these things, and if they did that, and make it fairly simple and succinct, then I think it would help all of us for the future.

It is something you have to learn by doing. You cannot go on a big grant scheme and say this is the way you are going to do it. It is a very delicate area, because you are impinging on the integrity of a whole profession.

Senator MUSKIE. How long have you been involved in this?

Mr. ALLEN. We have been doing this about 2½ years.

Senator MUSKIE. Are you considering now that you are right into the problem?

Mr. ALLEN. We are right into the guts of it.

Senator MUSKIE. And you have made your presence felt?

Mr. ALLEN. Very much so, to the tune to several million dollars, and to the tune that the professional societies have become believers. They originally thought we were on a vendetta, trying to exercise bureaucratic power. Now they realize there are some bad apples in the barrel, and we expose them, not by names, but by case histories, so they become believers, and with them on your side, you can really get into the issue.

Senator MUSKIE. Do they go beyond believing, are they involved in self-policing activities of any kind as a result of your activities?

Mr. ALLEN. Yes, they are, to the extent that they have advertised our efforts. They have sort of chastised some of their own members, and to the extent that they have, it is a common subject we can discuss over the table. Before we would discuss it in the backroom.

Senator MUSKIE. I would like to compliment you again for what you are doing. I now yield to the Chairman.

Senator MOSS. Thank you very much.

I might say for Senator Muskie's benefit that they have recovered quite a large amount of money in Michigan.

Mr. ALLEN. Senator, we recovered actually, altogether maybe $10 million in between the various areas, but it is a $600 million program, and we have done it with only a 1-percent overhead in administration, in administering the whole program. Today 6 percent is the normal running figure.

Senator MUSKIE. How many people do you have?

Mr. ALLEN. In our whole bureau of medical assistance, paying the bills, doing the policies, the investigations, all of that, we have 312 people, and for a $600 million program, that is not many. In addition, I am reminded by my colleague, our public health people have about 60 or 70 that assist us in providing medical knowhow. Even so, it is a very low overhead and it has given a great rate of return.

We are getting $6 back for every dollar in the investigative function.

Senator MUSKIE. We may have you become part of the Senate Budget Committee staff.

Mr. ALLEN. I could not fight the traffic every day.

Senator MOSS. Nor the rain.

Well, we thank you very much. We do appreciate your appearance, and the things that you have contributed to our understanding.

Your prepared statement and the associated documents * will be made a part of the record at this point.

We do thank you.

Mr. ALLEN. Thank you.

[The prepared statement of Mr. Allen follows:]

PREPARED STATEMENT OF PAUL M. ALLEN

Good morning Senators, ladies and gentlemen. I am Paul Allen, chief deputy director of the Michigan Department of Social Services. With me this morning are Mr. John Neidow, director of our program integrity division and Mr. Donn Moffitt, supervisor of the medicaid investigation section. The department of social services is the single State agency in Michigan responsible for administration of the State's medical assistance program. Prior to assuming my current duties, I served for over 3 years as director of the Michigan Bureau of Medical Assistance, the agency directly involved in operations of the medicaid program. I am pleased to have the opportunity to share with you this morning Michigan's experience in curbing program abuse and fraud in its medical assistance program.

Michigan's medical assistance program is among the largest and most comprehensive in the United States. The program ranks 4th in size in the Nation and alone accounts for expenditure of over 5 percent of the total Federal funds appropriated for medical assistance. During the fiscal year ended June 30, 1975, the program disbursed nearly $615,000,000 for medical services and made service available to over 830,000 individuals or nearly 1 out of every 10 residents of Michigan. Benefits now provided cover the full spectrum of available health care services. At the same time administrative costs have been held to only slightly more than 1 percent of total benefit payments, one of the best, if not the best, cost/benefit ratios for all health coverage plans, public and private, in the United States.

Michigan's medical assistance program was among the very first State programs established under title XIX of the Social Security Act. As was the case in many States, however, the original Michigan medical assistance program was developed in a very short time span and, as a consequence, it was not possible to completely pre-plan detailed implementation of systems and procedures. The original system, therefore, did not provide adequate information and procedures with which to manage and control the program.

Michigan's initial program was operated through a contractual arrangement with a fiscal agent, Michigan Blue Cross and Michigan Blue Shield, which performed the claims processing function along with related activities. In 1969, the Michigan Department of Social Services, under the direction of the executive and legislative branches of Michigan government, initiated a project to design and implement an improved medicaid management program. Evaluation conducted in conjunction with this project indicated that substantial savings in administrative costs could be realized from assigning fiscal agent function to the State itself. As such, it was decided that the State would, in fact, act as its

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*See appendix 1, p. 85.

own fiscal agent and the development of a State medicaid system under the direction of the Michigan Bureau of Medical Assistance was begun. Implementation of the system and concurrent phase out of Michigan Blue Cross/Blue Shield began in April 1972 and was completed in March 1973.

This new system, one of the largest in the Nation, was successfully introduced because of the cooperative efforts of all concerned in the legislature, the executive branch, and the medical community. The acceptance of the new program by health care professionals, particularly, is evidenced by substantially increased enrollment in the program, and subsequent increased availability of medical services to eligible recipients.

The key to this cooperation and acceptance is the rapid, equitable payment of invoices submitted by providers made possible by a highly automated invoice processing system and extensive use of optical character recognition capability. As an example of the success of this system, Michigan's Bureau of Medical Assistance received and processed over 29 million claims for payment in calendar year 1974; 83 percent of all valid claims, regardless of source, were paid within 15 days of receipt and 97 percent of all such billings are paid within 30 days. Such rapid and effective payment of claims has made many problems evident in other States, such as factoring or selling of bills by providers at a discount, virtually nonexistent in Michigan.

The major thrust of the new medicaid management system in Michigan was to give all concerned better control over the financial and service delivery aspects of a burgeoning program, and to provide prompt, equitable payment to providers of medical services.

New System Working Smoothly

We believe the goal of prompt equitable payment has been accomplished as previously discussed. The new system is now producing a wealth of information with respect to cost of services, utilization of services, and quantity of services provided to clients. This information is current, extremely accurate, and has proven to be invaluable in program administration and in quickly isolating and resolving day to day problems. On the other hand, no system can obviate fraud and abuse by those so inclined to reap dollars from State and Federal largesse. However, an important output of our system is data relevant to inappropriate or excessive payments and an abundance of utilization review data which is essential to maintenance of program integrity. Through use of this data, it is possible to insure that claims submitted to the program are valid and that funds paid in error, as a result of over-billing or as a result of fraud or program abuse, are identified and recovered. Performance of this function, that is, assurance of program and fiscal integrity, has been assigned to the Program Integrity Division of the Michigan Bureau of Medical Assistance.

In 1971 with the creation of the bureau of medical assistance, the original medicaid fiscal management division was reorganized and charged with the responsibility to develop and implement programs for third-party liability, cost settlement and audit (institutional providers), and postpayment review of noninstitutional providers. Subsequently, the organization responsible for the majority of these programs was renamed.

The medicaid program integrity division is composed of two major sections: the medicaid investigation section and the third-party liability section. The medcaid investigation section is responsible for the investigation and disposition of all medicaid provider and recipient program abuse and potential fraud situations. (This is distinguished from public assistance eligibility fraud.) The third-party liability section seeks reimbursement from third parties who may be liable for medical assistance paid by the medicaid program.

The division's third-party liability section recovered $2 million last year from private insurance companies and other sources responsible for claims presented under medicaid. The total amount collected by the third-party liability section for the first 2 years of operation was $3.1 million. The administrative costs incurred to recover this amount were approximately $550,000 or a ratio of return of $6 to $1. The third-party liability goal for fiscal year 1976 is $2.7 million.

An even more impressive increase of recoveries from workmen's compensation, automobile no-fault insurance claims, medicare and other sources is expected next year when a new third-party resource data system goes into effect. The system, expected to get underway in 1976, will be linked to automated eligibility systems and will identify medicaid cases covered under other insurance. A possible $13.5 million savings per annum in the State's medicaid program is possible. The potential savings from such a system are even greater.

The cost settlement and audit portion of division is now a separate unit, specializing in cost settlement of institutional providers.

The medicaid program integrity division's small regulation and review unit reviews and interprets Federal legislation pertaining to long-term care providers. This unit also serves as the coordinator on all complaints and reports of abuse in long-term care facilities, i.e., nursing homes, and with related medical providers.

Finally, Michigan's postpayment review program is incorporated into the activities of the division's medicaid investigation section. An explanation of this investigative function is the main reason I am here.

Under title XIX, medicaid program regulations and guides, the single State agency is charged with the responsibility for determining when there is valid reason to suspect that fraud (or program abuse) has been committed and whether claims submitted represent valid obligations to the program. Our response to this charge, we believe, is a key element in the successful administration of a medicaid claims processing system. From a management perspective, it closes the loop! We established, within general guidelines published by HEW, a unit in the bureau of medical assistance to investigate program abuse and fraud. Specific procedures, techniques, and methods of operation were developed and tested as we gained experience.

Investigation Unit Aids in Deterrence

The investigation unit conducts investigations of noninstitutional providers (e.g., physicians, pharmacies, ambulance companies, etc.). An examination and analysis of provider billings, program payments, and provider office records is made and verified with recipients of such services to substantiate the accuracy and legitimacy of billing and payment. As a deterrent to program abuse and fraud, and as a mechanism to recover overpayments, a determination is made as to actual delivery of medical services and an evaluation made of provider pricing policies and practices.

Major functions of this section are detailed as follows:

(A) Specialized in-office and on-site reviews and investigations of providers' billings and related records.

(B) Verification of services performed by examination of providers' records and direct contact with recipients.

(C) Profiling and analyzing claims in suspected situations of overuse, misrepresentation, or other program abuse by providers and recipients.

(D) Verification of compliance with all rules, regulations, and procedures of the program by providers and recipients.

(E) The development of cases which may lead to refund, removal from program participation, and/or criminal prosecution.

The investigation section's review is primarily fiscal in nature, but coordinated with and supported by the Michigan Department of Public Health who serve as our medical professional consultants. Michigan Department of Public Health medicaid program review findings conducted on our behalf are coupled with other fiscal and administrative evidence to build a case for and by the investigation section. These combined public health and social services activities result in the medicaid program integrity effort.

The investigation section is made up of four units: the medical, the paramedical, the pharmacy, and the office services unit. The medical unit investigators deal strictly with matters involving all practitioners, clinics, dentists, and chiropractors. The paramedical investigators are assigned all other noninstitutional provider cases except for pharmacy. The pharmacy unit reviews pharmacies participating in the medicaid program and the office services unit, composed of analysts and clerical staff, prepares provider profiles, extracted from automated invoice data, and furnishes analytical summaries of a provider's practice to other units in advance of an on-site provider review or prior to contacting recipients.

You may be interested in the background of personnel employed in our medicaid investigation section. Our supervisory people possess investigative backgrounds and skills with experience in medically related programs and activities. The supervisors are supported by a variety of backgrounds, educations, and experience. A cross section of the group is as follows:

(1) Investigation supervisor, medical boards, Michigan Department of Licensing and Regulation.
(2) Detective Sgt., Lansing Police Department, Metro (narcotics) Squad).
(3) Detective Sgt., Lansing Police Department, B.S. criminal justice.
(4) Registered pharmacist, retail and institutional experience.
(5) Former drug salesman.
(6) Former military corpsman.
(7) Registered nurse.
(8) Medical lab technician.
(9) Dental lab technician.
(10) Investigators, B.S. School of Criminal Justice, Michigan State University.
(11) Analysts.
(12) Stenos/clerks.

Reviews of medicaid providers or medicaid recipients by the investigation section may be generated by:

(1) Other providers, recipients, individual citizens, or county and regional office staff complaint.

(2) Unusual patterns or profiles of care or high medicaid dollar volume in relation to similar providers as compared by the invoice processing system (bill paying mechanism) and public health's surveillance and utilization review system.

(3) Return of an explanation of benefits (statement of medical services paid by Michigan medicaid) from the client or his representative indicating a discrepancy or specific complaint of program abuse or possible fraud.

(4) Referral from our inspector general's office, public health field staff and law enforcement agencies and the investigators of the department of licensing and regulation.

(5) SRS, SSA, and medicare intermediaries and carriers.

(6) Consumer, citizen, and patient rights groups.

$1 Million Recovered in First Year

In the first year of operation, fiscal year 1974, the investigation section recovered in refunds to the program approximately $1 million. The review and estoppel of these billing practices by these providers in 1973–74 caused an additional savings to the program of approximately $665,000. The administrative cost for this operation for fiscal year 1974 was approximately $285,000. This is also a $6 return for every dollar invested in the postpayment review program. During 1974–75, the actual refunds recovered by the medicaid investigation section was $1.2 million. The intangible savings for this fiscal year was $561,000. The administrative cost for this fiscal year approximated $380,000 for cost to a $5 recovery ratio. This ratio of return was decreased due to provider resistance and the addition of new personnel in training. Since the first of 1975, 35 providers have been suspended from the medicaid program in Michigan for program abuse while 8 have been terminated. Prosecution has been instituted on a number of providers through local county prosecutors.

The typical postpayment review process may be summarized as follows:

(1) Prior to any discussion or contact with the practitioner, the significant sampling of the practitioner's billings is analyzed by social services and public health analysts.

(2) Data for analysis is obtained from our automated invoice processing system and from microfilm records of original billings and related documents.

(3) Categories of information examined and analyzed are type and frequency of procedures, possible overuse trends, pricing structure, duplicate billings, etc.

(4) If steps 1 thru 3 produce information which indicate potential program abuses, fraud, or other problems, then notice is given to the provider of the desire to conduct an on-site review at his convenience. A notice of impending review is furnished the Michigan Department of Public Health.

(5) The physician is phoned for an appointment. The date and time agreed upon are confirmed by the bureau of medical assistance with a letter.

(6) Prior to a conference with the physician, we may, if circumstances warrant, interview medical assistance recipients or patients who have been provided with services by the physician. The recipient is interviewed as to physical complaint, nature, and date of services rendered.

(7) If the results of steps 5 and 6 warrant, we may request that the physician have readily available at the time of the review his medical records for specific patients identified by the review team.

(8) The on-site review with the provider or his representative may involve specific cases. In any event, the on-site review includes, but is not limited to:

(a) Compare physician billings, office medical records, and patient interview results.

(b) Verify services performed by patient records, e.g., X-rays, lab tests, EKG's, etc., report and results on file.

(c) Verify usual and customary charges and that billings are not in excess of usual and customary charges to the general public.

(d) Determine if extra charges to the patient are being made contrary to program regulations.

(9) Review team employees are "medical knowledgeable," i.e., pharmacist, medical lab technician, former drug salesman, navy corpsman, etc., and record and refer possible overutilization of quality of care problems to the Michigan Department of Public Health for further examination and review by a physician.

Based on the above and input from the Michigan Department of Public Health with respect to any referrals to that agency, we issue a statement of findings to the physician. This statement outlines, where appropriate, overutilization, over-charges, duplicate billings, violation of specific program rules, and may specify a certain monetary amount that is refundable to the program based on our subjective findings. The physician is given an opportunity to respond to our findings in writing and via informal conference.

Review Process

If necessary, there may be an expansion of the original on-site and desk review to reconcile differences of opinion. These arrangements are also confirmed in writing. If the physician feels it necessary, we are agreeable to meet with his attorney and/or peers. When all informal procedures or review conferences have been exhausted and the bureau feels there is still money due the program, the provider may request a formal hearing under chapter IV of the Administrative Procedures Act of 1969. The hearing is before an administrative hearings law judge of the department's bureau of administrative hearings. This series of events gives each provider due process under various administrative procedures.

After the above steps, the bureau of medical assistance will take action to recover moneys from the provider's account and terminate his participation in the program through legal or other means if deemed necessary. The provider has recourse, in turn, to the courts.

These activities and processes have been reviewed, discussed and endorsed by both the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons. In fact, Michigan's Governor Milliken created a standing liaison group between government and the professional societies during the early implementation and assumption of the Michigan medical assistance program by State administrators to reasonably assure a smooth transition to the new system and create good communication between the State and all medical providers. The success of this approach is attested to by a statement in the Michigan State Medical Society's report of May 5, 1975, wherein it was recommended by the society's council: "That the Michigan State Medical Society strongly support the Michigan Department of Social Services in its efforts to limit abuse of the medicaid program through medical and financial audit of providers with a demonstrated pattern of overutilization; and further that the MSMS Judicial Commission be requested to take appropriate action against MSMS members who abuse the program and that MSMS request the Michigan Medical Practice Board to investigate and take action against members of the medicaid program who are not members of MSMS."

Briefly, the principle review findings can be summarized for major noninstitutional provider types as follows:

Practitioner

(1) Physicians are in general practice.

(2) An unusual number of medicaid patients are seen each day.

(3) The same patients are seen on a repetitive basis, e.g., several times per month without substantiation of medical necessity.

(4) Diagnosis and treatment patterns are relatively unsophisticated, e.g., nasopharyngitis—office visit and injection.

(5) Patients are given an unusually high number of laboratory tests, radiology, EKG exams and/or injections on every visit (very high costs per visit result) without substantiation of medical necessity evidenced by diagnosis, history, or medical records.

(6) Billing incorrect procedure code for the services. (At higher rate than correct procedure code.)

(7) Claims are incorrectly billed to the system.

(8) Billing above "usual and customary" charges to the general public.

The magnitude of this problem is readily apparent when it is observed that less than 2 percent of the 13,500 enrolled physicians in Michigan are being paid 25 percent of the medicaid dollars available for physician services. In fiscal year 1975, this means 200 physicians received about $25,000,000 from this program.

Pharmacy

(1) Inaccurate acquisition cost reporting.

(2) "Prescription splitting" (billing for less than 30 days supply of maintenance therapy drugs in a long-term care facility).

(3) Generic substitution for brand name drugs (charging the higher proprietary fee).

Laboratory

(1) The laboratory performs additional tests not ordered by the physician and bills the program.

(2) The laboratory bills incorrect procedure codes for the service. The billing reflects laboratory tests performed manually, whereas semi-automated laboratory tests were performed. The billing for manual tests results in a higher payment to the laboratory.

(3) Laboratory tests are billed to the program, but the findings for these tests are not substantiated in laboratory records.

(4) The laboratory bills for the same service twice by falsifying dates of service.

Nursing homes[1]

(1) Overutilization of and unnecessary ancillary services rendered patients (e.g., physical therapy, optometry, podiatry, pharmacy).

(2) Abuse of patient trust funds.

(3) Abuse of patient pay amount of excess income.

Other Non-institutional Provider Types

Examples of other provider type abuse found in Michigan are summarized in the report of our medicaid investigation section included in the material made available to the joint committees.

We appreciate very much the opportunity to appear before your committees. Thank you.

Senator Moss. We will now hear from Mr. William L. Hood, investigator and coordinator of the Better Government Association, from Springfield, Ill.

Our colleague, Senator Percy, is well acquainted with the Better Government Association, and he made reference to it earlier. I know he particularly would like to welcome you here to testify.

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[1] Audits involving nursing homes are now conducted by our new cost, audit, and ratesetting division. However, our program integrity division reviews noninstitutional providers rendering services in nursing homes and coordinates abuse findings and complaints with other bureau of medical assistance divisions and public health.

Senator PERCY. We certainly do, and I wish again to pay tribute to BGA, and to the Chicago, Ill., news media for having worked so effectively together with their investigative squads, to serve as a watchdog over the public interest. The BGA has rendered an invaluable service, and I pay tribute to your board, your officers, as well as your staff.

Senator Moss. Will you proceed, please.

STATEMENT OF WILLIAM L. HOOD, INVESTIGATOR AND COORDINATOR, BETTER GOVERNMENT ASSOCIATION, SPRINGFIELD, ILL.

Mr. HOOD. Thank you, Mr. Chairman.

I am William L. Hood, Jr., State coordinator for the Better Government Association of Illinois. The BGA, as we are commonly known in our State, is a 50-year-old, nonpartisan, citizen's watchdog group. The general mandate of the BGA is to investigate instances of waste, corruption, and inefficiency in all levels of government in Illinois.

My testimony today concerns the medical delivery system designed to help impoverished citizens. Specifically, for the last 2 years the BGA has investigated many facets of the medicaid and medicare service industry.

One of the most alarming findings we made concerns the practice in Illinois whereby doctors, pharmacies, ambulance companies, laboratories, nursing homes, and even hospitals sell their accounts receivable from the government to factoring firms.

It is our general conclusion that deficiencies and inordinate delays in the payment of accounts due have caused the factoring industry in our State to mushroom. The harm that we see from the intrusion of these middle men is that a significant percentage of funds appropriated by Congress to be spent on medical care are, in fact, never spent on such care of services.

Instead, 10 percent, 12 percent, 15 percent, and even 24 percent of the moneys end up in the pockets of the factorers.

This problem was first disclosed in a BGA investigation conducted jointly with a Chicago newspaper, Chicago Today, and its chief investigative reporter, Charles Neubauer, in 1974. We also got investigative assistance from WMAQ-TV in Chicago and NBC reporter Rich Samuels.

Chicago Today subsequently merged with the Chicago Tribune and Mr. Neubauer and Pulitzer Prize winner George Bliss have continued to disclose, along with the BGA, aspects of this scandal.

The factoring system in its bare outlines is very simple.

SLOW PAYMENT "CREATED" FACTORING SYSTEM

The doctors who have a high percentage of medicaid patients often have to wait from 6 months to more than 1 year for payment. This, of course, creates a cash flow crisis for doctors, pharmacists, and other purveyors of medical care who must meet payrolls and other necessary overhead.

The factoring firms step in and offer to pay cash for the accounts receivable minus a hefty percentage.

Many medical providers found the offer initially attractive and signed what later turned out to be very steep contracts.

Some eventually ended up paying thousands of dollars back to factoring firms because factors alleged that the State department of public aid had disallowed many claims. Further costs were extracted from what the doctors received for so-called reserve funds.

Factorers obtained an advantage in Illinois when medicaid claims burgeoned in the early seventies. The Illinois Department of Public Aid computer can only handle a maximum of 750,000 claims monthly.

Today, and for the past 2 years, the IDPA has faced a flood of 2.5 million claims per month.

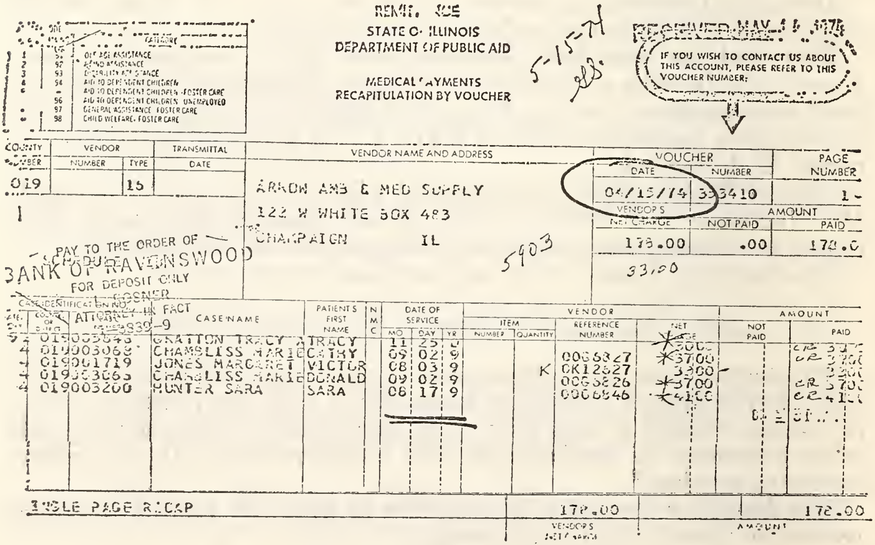
An inadequate and inept staff has tried to bridge the gap with manual labor. While the hand sorting has helped, the gap between billing and payment remains large.

The GAO has been highly critical of this Illinois department and its use of the computer. Some doctors and other medical providers in Illinois believe this antiquated system has been retained deliberately to force the use of politically-connected factoring companies.

At times the payment gap has been ridiculous. Many doctors told us that 1 or 2 years ago, it was not uncommon to wait 6 months, 9 months, or 1 year to receive payment from the State. If IDPA challenged a bill or a doctor coded it improperly, the bill would have to be submitted again. And, in some cases, a third and fourth time.

Today the gap is still 40 to 120 days, and if it has to be resubmitted, all the way up to a year. Arrow Ambulance had to wait 5 years for this bill to be paid (see below). This inordinate delay in payment caused medical providers great problems. This is especially true of those who had a high proportion of welfare clients.

The factoring firms provided what seemed to be a sound business deal to providers with cash flow problems of those disgusted with paperwork and the exasperation of rejected bills.



	CATEGORY
91	OLD AGE ASSISTANCE
92	BLIND ASSISTANCE
93	DISABILITY ASSISTANCE
94	AID TO DEPENDENT CHILDREN
–	AID TO DEPENDENT CHILDREN - FOSTER CARE
96	AID TO DEPENDENT CHILDREN - UNEMPLOYED
97	GENERAL ASSISTANCE - FOSTER CARE
98	CHILD WELFARE - FOSTER CARE

REMITTANCE
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

MEDICAL PAYMENTS
RECAPITULATION BY VOUCHER

5-15-74

RECEIVED MAY 16 1974

IF YOU WISH TO CONTACT US ABOUT THIS ACCOUNT, PLEASE REFER TO THIS VOUCHER NUMBER:

COUNTY NUMBER	VENDOR NUMBER	VENDOR TYPE	TRANSMITTAL DATE	VENDOR NAME AND ADDRESS	VOUCHER DATE	VOUCHER NUMBER	PAGE NUMBER
019		15		ARROW AMB & MED SUPPLY 122 W WHITE BOX 483 CHAMPAIGN IL	04/15/74	333410	1

VENDOR'S NET CHARGE	AMOUNT NOT PAID	AMOUNT PAID
178.00	.00	178.0

33,00

5903

PAY TO THE ORDER OF
BANK OF RAVENSWOOD
FOR DEPOSIT ONLY
ATTORNEY IN FACT
9339-9

CAT.	CASE IDENTIFICATION NO.	CASE NAME	PATIENT'S FIRST NAME	NMC	DATE OF SERVICE MO	DAY	YR	ITEM NUMBER	QUANTITY	VENDOR REFERENCE NUMBER	NET CHARGE	AMOUNT NOT PAID	AMOUNT PAID
[illegible]	0190035[illegible]	GRATTON TRACY A	TRACY		11	25	[illegible]				*500		CR 3
4	019003068	CHAMBLISS MARIE	CATHY		09	02	9			0066327	*3700		CR 370
4	019001719	JONES MARGARET	VICTOR		08	03	9		K	0K12627	3300		330
4	019003065	CHAMBLISS MARIE	DONALD		09	02	9			0066826	*3700		CR 370
4	019003200	HUNTER SARA	SARA		08	17	9			0066846	*4100		CR 41

SINGLE PAGE RECAP	VENDOR'S NET CHARGE		AMOUNT
	178.00		178.00

DOCTORS FORCED TO LEAVE

Many doctors in Chicago's poorer areas have moved their practices to other areas—where they do not have to wait months and years for payment, leaving a serious gap in health services to the elderly poor.

Factoring firms offer cash for accounts receivable minus 12 percent for medicaid and 18 percent for medicare bills. They also promise to increase billings because they know the maximum allowed in each category. Many honest dedicated doctors have turned to these factoring firms to save them from bankruptcy. They had no way of knowing that the contracts they were signing would cost them more than the already steep 12 percent.

Some would become involved in potentially illegal activities. Others, such as Dr. Carrell Hutchinson, would be sued for thousands of dollars of alleged "overpayments."

One of the major factoring firms in Illinois is Farnsworth and Associates. Farnsworth officials have stated that their medicaid billings ran close to $10 million last year. Of this $10 million it is likely that they receive a minimum of 15 percent, or $1½ million.

Until this week the factoring firms such as Farnsworth and Associates have had an anomalous status. Because of new legislation they will now be known as Medical Services Finance Companies and will be under some slight supervision by the Illinois Department of Registration and Education.

In the past, officials of Farnsworth contended to State officials that they were no more than collection agencies and thus not subject to jurisdiction of the department of financial institutions.

A year later, in late 1974, when the Bureau of Collection Agencies attempted to regulate them, Farnsworth contended that they were not collection agencies any longer but were financial institutions. The company then filed a lawsuit in March of this year to halt regulation and began working behind the scenes to secure favorable legislation. Such legislation, purporting to license medical factoring companies, did pass very quietly through the Illinois legislature.

The legislation, signed into law 3 days ago by Gov. Daniel Walker, will be of scant assistance in properly regulating these firms.

DOCTOR RECOUNTS REASONS FOR USING FACTORERS

Dr. Alan Hester, an Oak Park physician whose patients are 90 percent medicaid, told the BGA how and why he came to use a factoring company to collect his bills against the State.

These are Dr. Hester's words:

> In many cases it was taking me 10 months to a year to collect from public aid. Much work that I had done 6 and 7 years ago in my practice and in several nursing homes had never been reimbursed.
>
> One day in 1972 a salesman for one of the factoring companies walked into my office. He was from Professional Medical Guidance Corp.—PMGC. He told me that he could help me get paid immediately for my medicaid bills. He picked up the telephone at my desk and called Springfield and was able to tell me immediately my public aid department profile and the amount of money due to me. This confidential information is more than I could have found out for myself.
>
> He told me his company could get me more money. They said they could collect 150 percent more than I could. And he threw around the names of several big politicians I had heard of.

> Later, I was taken to a party by this company and one of the guests was a man who processes the bills in the State public aid department. He gave a speech and told the doctors they were much better off using that factoring system.
>
> I use this company because they can get more money for me than I can get—and they pay my bills within a week.

Dr. Hester did not know that the salesman was a convicted felon, a man who pled guilty 2 years earlier to bribing public officials. Nor did Dr. Hester know that PMGC would routinely alter his medicaid bills upward.

The man who spoke at the PMGC party was one of several State officials who was later forced out of the public aid department for taking expensive gifts from PMGC.

Dr. Shirley Roy told the BGA she signed a factoring contract with Farnsworth and Associates in the summer of 1973. Farnsworth charged her 17 percent on medicare papers and 12 percent on medicaid bills.

Dr. Roy fills out the papers, signs them, and turns them over to the factoring company. The head of Farnsworth, Richard Abrams, told Dr. Roy that his company recodes the papers before sending them. Dr. Roy, however, has never seen what Farnsworth submits in her name.

It is standard practice for all payments to go directly to the factoring companies. Doctors never learn what bills are actually paid or the amounts paid.

Dr. Roy gave an example of what happens when she turns a bill over to her factoring company.

On a particular $300 bill the factors may conclude that medicaid will only pay $200. They then issue her a check for that amount minus 12 percent of $176. If for some reason the bill is rejected, the factors will take $200 back from her reserve account.

Dr. Roy told us bluntly, "I think it's juice money, but I need it."

The owner of Twin Oaks Pharmacy in Oak Park, Ill., told BGA investigators he thought his factoring company—Farnsworth—might be altering his medicaid bills after he turned them over for payment.

Many Bills Increased

BGA staff members examined a bundle of 3,569 prescription slips on file at the State comptrollers office. They found that 1,711 bills had been altered upward. Another 186 had been reduced.

The facts told by Drs. Hester and Roy are typical of dozens heard from other medical providers in Illinois who are caught up in the trap of using factoring companies to survive financially.

Many Illinois medical providers are openly envious of the Michigan system we heard about earlier.

Similar prompt payment of legitimate claims would eliminate any need for factoring companies in Illinois. Until that time, we will continue to see millions of dollars appropriated for medical service to the elderly and the poor go, not for medical services, but siphoned off into the pockets of unnecessary middlemen.

That is the end of my prepared statement.

Thank you.

Senator Moss. Thank you, Mr. Hood, for your statement on this question of factoring.

You said that Illinois now does have a law of some kind of supervision on factoring?

Mr. Hood. Senator Moss, we have a law that slipped through the legislature so quietly that the department which should have any contact never knew it was going through. It was kept a secret by the Governor's office. It was one that went through last Tuesday.

The Governor has not yet made public his amendatory veto of it, so I do not know. I do know that some provisions are there to keep each State agency from having access to these factoring companies records.

The law forbade State agencies from not doing business with the factoring company for a time. For a time the State department of public aid tried to send payments to the doctor to cut out the middleman, and a lawsuit charging breach of contract stopped that sort of system, so for the moment, I cannot tell you anything has happened.

Now, we have a new amendatory veto process, whereby the Governor can make recommendations, and if the legislature does not override them, then the amendatory veto will stand as the law. I do not know what they are, because he has not released them, but I understand that his veto is amendatory.

Senator Moss. When will the legislature have a veto session?

Mr. Hood. They will have first crack at it in about 4 weeks.

Senator Moss. So we will not know until after that session has been concluded, whether this becomes law?

Hearings Probable

Mr. Hood. I will guarantee you there will probably be an attempt to have some hearings, because when this law first went through last spring, there were no hearings announced to the public. No one of any interest except perhaps the factoring companies were ever able to testify, and the bill was apparently written by a lobbyist for the largest factoring company in the State.

Senator Moss. Is this factoring system of longstanding in Illinois, and does it predate medicare and medicaid?

Mr. Hood. Senator, it is not very old at all. The earliest—I will try to go back and find the earliest possible factoring company in this field—was started by a man in 1968, 7 years ago, who lost his job with the department of public aid, and he offered to help doctors prepare bills so they would get paid faster.

He did not ask any contracts be signed as they are signed today, and he only asked for 2 percent instead of 12 or 17 percent, so it is only a 7-year-old industry.

Basically the large factoring firms which are now booming in our State only came into being in late 1972 or 1973. I think they have their eye on something bigger in the future. They are sort of testing it out in Illinois.

Senator Moss. You said that the check, when it is made, goes directly to the factor and not to the person who rendered the service, and consequently the doctor has no way of checking on how much is collected?

Mr. Hood. That is correct, and the bills which are submitted back, or the statements of accounts which are submitted back to the doctors, I have looked at dozens of them, and I must admit, I am as perplexed as most of the doctors to know under what method, that is, to understand what they mean.

They do not show any information that would give a doctor an opportunity to compare the money he was getting, let's say with that slip of paper, with anything he had submitted to the factoring company. It is purposely jumbled, I would say.

Senator Moss. The example you gave of how a factor might, if the bill were rejected, get the full $200 from the reserve setup, rather than $176 that he paid off, means he takes no risk at all.

Mr. Hood. Absolutely. This is the greatest no-risk business in the United States.

I have heard, there was a question which Mr. Halamandaris posed to other people.

I have talked, only yesterday afternoon, with a subcabinet member of our State government, I will not name him, he might lose his job tomorrow, but he told me that one of his great worries is that if we have national health care, these firms will become the greatest ripoffs of our country. He also told me he worries very much that organized crime already has a toehold in the State of Illinois, and he worries it will get much worse in the next year or so.

He did not give me specific names I can document to you, but he is a person that works in this field every day, and is concerned about it. He is a professional, and he has genuine fears about this sort of thing.

Senator Moss. Well, this is a problem, of course, that we will have to deal with.

Factoring Companies Find Loopholes

Reading from an article that was in the Albuquerque Tribune in February of this year, about this matter of factoring, and it says Congress tried to outlaw the practice 2 years ago with legislation, but the factors got around the law by having physicians supply them with a power-of-attorney.

This permits the factor to submit a claim in the physician's name and cash the check when it is paid.

Are they using that system in Chicago?

Mr. Hood. Exactly. They do have to sign a power of attorney.

Another instance of controlling the factoring firms with doctors, is that many doctors have presigned State forms without any prescriptions being written on them, without medicaid, without any diagnosis, they just sign the forms, and the suspicion by some of these doctors is that the forms have been filled in by the factoring company later, and the money collected by the factoring company, perhaps never to get into the pocket of the doctor.

Senator Moss. Are these factors subject to any kind of audit?

Mr. Hood. They contend they are not. They have slipped and wheezled and scurried under the tables, until this law was passed, and we still do not know the effect of it. They have been a totally unregulated bunch. They have kept changing their status.

Senator Moss. Now, you pointed out the reason that probably caused them to arise, is the slowness in the paying of the accounts.

If we could induce efficiency so that a doctor could get paid within not more than 30 days, would that depress this factor racket?

Mr. Hood. I think that this racket would be essentially wiped out in our State. We could have efficient payments, and it is hard for me, and hard for a number of people including the former director of the department of public aid, who left in a fight with our Governor, to see why they would not put in the money to buy a new computer, or optical scanning device like Michigan has.

We are processing the third highest number of medicaid bills in the United States, we are spending over $750 million in medicaid, another $500 million in medicare, and it is a totally antiquated system.

The staff has been shortchanged all the time in Illinois, instead of adding new people to help out with the manual labor, the politicians loaded up the payroll with almost 100 people doing political work, to go out to campaign, and who never see the offices, and they are eating up the budget.

Senator Moss. Is the description that was given by the Michigan group with respect to the Illinois program being snowed under by a lot of paperwork, accurate?

Mr. Hood. I could see it in my mind's eye, Senator.

The amount of paperwork is absolutely staggering, and yet they persist in trying to do it by hand. You could take a cash outlay to put in a sophisticated computer system, I think it would pay for itself in a very short time.

Senator Moss. In your statement, you said other doctors such as Dr. Hutchinson, had been sued for thousands of dollars for alleged overpayments. Who brought that suit?

Doctor Initiates Investigation

Mr. Hood. Farnsworth. Farnsworth factors sued Dr. Hutchinson who happened to be the only doctor I ever found that kept every scrap of paper he sent to them, and every scrap of paper they sent back to him. Dr. Hutchinson, I would give credit to helping all of us in starting this investigation, which we began over 1 year ago. He went around to everybody, including the news media, to the Better Government Association, and he finally got a response by us, and we started to check into the allegations. They were very complicated. They involved hundreds of bills which had been submitted. The upshot of Dr. Hutchinson's case is that he allegedly had been paid too much by his factoring company on a number of his bills. They had been discounting his bills at 12 percent. They had taken another 5 or 10 percent, put it into a reserve fund.

The factors after a year with the doctor, said "you had a high rate of rejections by the State Department of Public Aid."

"We have had to take out $7,000 more of our own money that you had in your reserve account" and they sued him for the amount, but they could never satisfactorily account for any of the moneys. So there have been other doctors also with similar situations.

We had another doctor who was sued for almost $30,000, and then when he protested, the factoring company offered to loan him that money on a 90-day basis at 18 percent for repayment.

Senator Moss. There is a story in the Chicago Tribune on the 5th of May by George Bliss that suggested organized crime was making an effort to take over nursing homes and pharmacies receiving large amounts of medicaid funds, and it reports further that the crime syndicate has moved into the factoring business, and is buying medicaid bills at a discount, collecting from the State welfare agencies.

You have been describing some of this to us. Do you observe that there is any of the crime syndicate getting into it?

Mr. Hood. I believe from the facts that I now know, the facts that I have heard from Federal investigators and State employees, that organized crime does have a foothold in Illinois.

However, I do not know all of the names, or even very many of the names of the people who were involved in this sort of thing.

It is obviously something they will not put a neon sign up and say the mob runs this factoring company, but the amount of money that can be made out of factoring is better than you can make out of loan sharking, and there is simply no reason to take all of the legal risk of loan sharking, when you can make as much money in the legal way.

Senator Moss. That seems to be to me the way you describe it. Their presence and income is pretty well guaranteed. They are not going to lose any money, and they will get, as you say, as high as 24 percent on some.

Mr. Hood. I would be glad to speculate, not only get as high as 24 percent, Senator, but in some cases, they might get as high as 144 percent.

TIE-IN "OBVIOUS" WITH STATE EMPLOYEES

Let me interject here, one of the things which is a problem in Illinois. Some of these factoring firms have an obvious tie-in with a number of employees in the State of Illinois, and these employees were processing bills brought in by factoring companies very rapidly. The factoring companies cleaned up the bills, and hand carried them into the Department of Public Aid offices, actually to the specific clerk that they knew handled this section.

Some of these bills that were handled by factoring firms had been turned over 30 days or less, even the time when we had a year delay for regular doctors, the same time as clerks were helping out, they were getting bonuses, gifts, cash, television sets, from some of the factoring companies, and some of these employees were forced to leave, but I think not all of them have left.

At any rate, the honest doctor who sends in his claim, he was having his stuff put aside. Whereas the people who came in from the factoring company were having it hand carried right to the proper clerk, who were going over it, handing back the rejected bills to the factoring company to reprocess, and getting the checks made out.

If you could get a 12-percent discount on a doctor's bill, the doctor has $1,000-a-month billings, and you are discounting $120 a month, that is not 12-percent annual rate. You are getting this money back every month, you are going to do it 12 times a year.

The amount of return on that is even greater than some of the amount of return we have seen in nursing homes.

Senator Moss. You have put it in the ultimate. Well, that is very interesting, and a great story that you are telling us about, this growth of factoring. It has many areas of peril, and as you point out, if we get a national health bill of some sort and get caught up in this sort of thing, it would be the greatest ripoff of all time, I guess.

Senator Muskie.

Senator Muskie. I yield to Senator Percy. It is his State, and if there are any questions left over, I will be glad to ask them.

Senator Percy. Thank you, Senator.

I was amused at Mr. Hood's understatement that organized crime had a foothold in Illinois.

My 55 years of residence would leave me to believe they have some foundation there, and that they have been building a long time. Whenever they see a program or problem like this, they generally move in. Their front is legitimate business, but they have the working capital which comes from illegitimate business.

Mr. Hood. Senator, you are absolutely right, if I may interject. They have a giant foothold around the city of Chicago, and in this particular industry, we know of several small loan companies which are run by organized crime members, and a possible extension for a loan company to go into is a factoring business.

Pardon me for interrupting.

Senator Percy. I appreciate that clarification.

I would like now to run right through your statement for some specificity.

Altering Bills To Cover Fees

Do I get the implication from your statement that really these factoring companies will come in and, in a sense, say this will not cost you anything because we can add to your bills?

We know how much you can really charge for these services, and then, in a sense, they up the bills. The cost to the State and the Federal Government, and, you might say, to the customers that they are calling on, the net cost is really not 15 percent. Certainly on the last page you indicate the extent of the adjustments that have been made. So really, it is adding totally to our costs, and the Government is paying these collection charges.

Mr. Hood. As an example, to give you some specificity, one of the doctors we interviewed showed us his records, and he only charged $3 for a urinalysis test, and that was part of his general examination. His factoring company routinely raised that amount to $4, even though he thought it was $3.

Senator Percy. That is a 33-percent increase.

Mr. Hood. It is a 33-percent increase, and this doctor had several hundred patients a week.

Senator Percy. So if the factoring cost is 15 percent, we are paying for it.

Mr. Hood. And there are dozens and dozens of examples like that. What happens is the factoring companies learn what a profile is.

There is an average community standard called a profile, and public aid or medicaid will pay 70 percent of this. Many doctors do not even charge up to the medicaid standard. The factoring companies know to the penny what this standard is for any type of examination by a doctor, any type of diagnosis, for surgery, any sort of pharmaceutical, and if they find that the doctor has put anything less, they immediately raise it.

Senator Percy. Would you say it is the inefficiency of the system that really brings this about and creates the climate, that it lives on inefficiency? If, for instance, Illinois had the efficiency of Michigan, some of the medical practitioners apparently have looked with great favor on their system; they would prefer it. They prefer to deal direct with the State and get their money. But they are beset by the bureaucracy. And then there is no real incentive, if you have got political kickbacks, political connections in the Department of Public Aid to ever improve the system. The pressure from the factoring companies is to keep it inefficient, because that is the way they make their livelihood, is that correct?

Mr. Hood. That is correct.

Senator Percy. In the middle of page 2, you mention politically connected factoring companies. Now, by politically connected companies, I want to be certain we are not imputing anything illegal or immorally wrong. There is nothing wrong with a company or labor union contacting their representatives to lobby them on legislation, or whatever it may be. In giving these names in the first instance, I want to assert that you would be giving the names of a company that we are not necessarily condemning.

Political Influence Used by Factories

The question is how do they use their political influence? Can you give us the names of some of the companies from your experience, factoring companies, that you consider have political connections, and make use of the political process?

Mr. Hood. I would like to point out that two of the biggest in our State are Farnsworth & Associates, and PMGC. They have a lot of the business, and they have an amazing relationship with officials at high levels. I was told they also seem to make campaign contributions. They have an entree which other people do not seem to have, which is part of what I mean by political connections, but I would name Farnsworth and PMGC.

Senator Percy. Is there a pattern of political contact? Is it through generally political appointee contact, one who heads the departments, or elected officials, that inroads to these departments are made? Or is it by wining, dining, whatever you might say, the working people, right at the working level, who are presumably civil servants?

Mr. Hood. Senator, in the specific case we are dealing with here, they skip the department head, because he happened to be interested in cleaning up the factoring system, they wined and dined other top level people in the department that handled the medical payments, and then they apparently were very close with members of the

Governor's staff, so they skipped the cabinet level and went right to the executive level.

Senator PERCY. On page 2, you may say many doctors said that 1 or 2 years ago it was not uncommon to wait 6 or 9 months to receive payments from the State. Has that situation improved?

Mr. HOOD. It has improved. The director of the Illinois Department of Public Aid, until a year ago last fall, and who now heads up an advisory commission, made great efforts to change the system.

He tried to go around the factoring companies by sending payments directly to the doctors, and a lawsuit stopped that. He could not take it any longer, the meddling in the affairs, the lack of support for his department, and he quit.

The man who took his place is James Trainor. I believe Mr. Trainor has made a sincere effort to improve things. There has been some improvement, and the average wait now is down to 40 to 120 days, which is at least better than it was, if not good. But there is always room for disaster.

We are still processing it by hand in Illinois. And we have a political problem, with $65 million a month flowing out of medicaid, out of the State treasury, any time the State has a cash flow crisis, the simplest way for a politician to help himself to ease the cash flow crisis is to slow down the medicaid flow. There are people, who I have talked to, who are very highly placed in the State government, who think this does take place.

COLLECTION AGENCIES OR FINANCIAL INSTITUTIONS?

Senator PERCY. In the middle of page 3, Mr. Hood, you mentioned, you do not use this word, but it states that they argued they were no more than collection agencies, and that they were not subject, therefore, to jurisdiction of the Department of Financial Institutions. But then later they claimed they are not collection agencies any longer, but financial institutions.

Is it the purpose of this to get under the regulatory group they might have the best connections with, or where the regulations would be, in their judgment, the loosest?

Mr. HOOD. I think that is exactly right. When they try to get to be financial institutions, I think they sought the softest rock they could crawl under. Today they will probably be regulated by the Collection Agency Bureau, which is the one they originally tried to escape from, but again we do not know to what degree.

Senator PERCY. You say the company, Farnsworth, was working behind the scenes to secure favorable legislation. Could you describe the behind-the-scenes process?

Mr. HOOD. I wish I could tell you more about this. I found out about the legislation the day before the Governor acted on it, as did most people in the departments.

I did hear the name of a lobbyist who allegedly took it around, Mr. Robbin. This legislation was sponsored by Arthur Berman, who is generally known for being a good, progressive legislator, and one is hard pressed to explain why he sponsored this legislation. He has not given much defense of it himself. I have been unable to contact him.

The behind-the-scenes action—the bill was put in at the end of the session, in the middle of April and was among the last bills going in the legislative hopper, and there was a floodtide at that time.

Later this bill was moved in sort of a massive movement of bills from one counter to another. Nobody saw it, nobody in the Governor's liaison staff ever contacted the affected State agencies which is the normal procedure. In fact, they never realized it was passed. The day it was in the Senate committee, there was a minimum quorum. We are still trying to piece that together, because the voting record cannot be found on that day. I can only give you a partial answer, I am sorry.

Senator PERCY. Can you tell us more about the political connections of Farnsworth and Associates?

Mr. HOOD. I cannot say that they are the brother-in-law of any politician in the State. That just is not true.

Mr. Abrams, who was head of the company, and his associates, seemed to know people at high levels. They seemed to have an entree to them; they take them to dinner; they may give them campaign contributions. They are always there. They always have the favored treatment, and I am sorry to say I cannot put my finger on it.

HEARING AID AND EYEGLASS REGULATION

Senator PERCY. I would like to point out to Senator Moss and Senator Muskie, a specific illustration. For many, many months, I have been working on the hearing aid issue. I had the feeling there was a gross overcharge of the elderly. Finally, I have made some real progress, I feel. We are getting money-back guarantees, et cetera. We have now started on the eyeglass industry—110 million people wear eyeglasses. For some reason a great many States have laws prohibiting advertising in connection with the price of eyeglasses. And in those States, generally the price, the same frames, the same glasses could be two to three times as much as in other States.

The American Optometric Association newspaper. The *News.* has dealt with this issue, I think, in a straight forward manner. They recognize they probably have a problem, but they have said, and I quote an article in their September issue, "that laws governing health care in all aspects are States' rights matters and should remain so."

Now, on your experience in working with the State legislature, do you think this is a deep philosophical feeling on their part?—a constitutional issue?—or is it just that the State legislatures are a little more amenable to their working quietly behind the scenes and, as you say in your testimony, very quietly passing a piece of legislation through the State legislature?

Mr. HOOD. I think you hit on the exact point, that in the State legislature, certainly with the experience that I have had, within Illinois for the most part, expediency is the rule, and the door is always open for a quiet word. A number of bills get through each year in quiet ways. They are fairly large in the State legislature.

As we are having an open hearing; looking down the road several years before taking legislature steps in the Congress; knowing what was done like this in the State of Illinois on the particular factoring bill; certainly BGA would have great interest in speaking if there had been an interest.

Senator PERCY. The Speaker of the House, Mr. McCormick, learned how lobbyists used their influence, picking up a telephone right on the Representative's desk, as a matter of fact, and using his office and making calls.

I was interested in one of the doctor's responses you outlined when a salesman of a factoring company came into his office, picked up a telephone, and as you say, on top of page 4, "immediately was able to tell me my department profile, and the amount of money due to me; confidential information I could not have found out about myself."

How do they do this? How can they get such information?

CONFIDENTIAL INFORMATION DISSEMINATED

Mr. HOOD. The salesman knew somebody in Springfield.

The information which he was talking about is a very carefully guarded profile. It is kept in big, bound computer books, and it shows: what that doctor has been billing; what community he is in; and how his profile stacks up against the standard. Only a few people have access to those books.

We could not pinpoint who he called, but it had to be a person at a fairly high level of the medical payment section of the Illinois Department of Public Aid.

Senator PERCY. You indicated that he threw the names around of several big politicians I heard of.

Now, we know that there are two possibilities, and I always, in a presumption of innocence, assume these politicians are innocent, and that someone is using their names without their knowledge. But I think they know who is throwing their names around. We ought to know who is throwing what names around. We also ought to know why their names are being used, and if there is any substance to it.

Will you tell us their names?

Mr. HOOD. It was not you, sir.

Senator PERCY. I am disappointed. I learned the other day that the CIA opened my son-in-law's mail in West Virginia and never opened mine. I felt left out.

Mr. HOOD. The name that Dr. Hester was able to recall the time we talked to him, was the name of George Dunne. For the record, he is the president of the Cook County board.

Senator PERCY. Well, I would say that is a big politician. I think Mr. Dunne ought to know his name is being used by factoring companies, and we ought to know why.

A man who processed the bills in the State public aid department you mentioned, who was this?

Mr. HOOD. Kilbreath is the man's name.

Senator PERCY. Do you have a full name?

Mr. HOOD. Initials—J. M. Kilbreath.

Senator **Percy**. What is meant by your term, "I use this company because they can get more money for me than I can get." I just want to be sure I understand what you mean, "get more money," not just the money that is owed, but more money.

Mr. **Hood**. I believe he was strictly referring to their ability to upgrade his profile, to raise the amounts on the bills he submitted to them.

Senator **Percy**. You mentioned a salesman who is a convicted felon, a man who pled guilty 2 years earlier to bribing public officials. Who was the salesman?

Mr. **Hood**. His name is Palmer, Senator.

Senator **Percy**. He works for whom?

Mr. **Hood**. He worked for PMGC.

GAO Cites Shortcomings

Senator **Percy**. Finally, the GAO report found that the Illinois system for paying medicaid claims needed improvement. The lack of accountability of claims, unnecessary manual processing, ineffective uses of computers, insufficient provider and employee training, delayed payments to medicaid providers for long periods, lead providers to turn to factoring companies to collect outstanding bills.

The State has started action to correct each of the management problems cited as told to GAO. It was also stated they have been successful in reducing actual processing time to 19 days for physicians and 15 days for drugs.

My question is, has Illinois in fact improved its system for paying medicaid bills?

In a sense you have answered that, but I would like you again to indicate on the record, what the present situation today is. Should we rest easy and feel all is well?

Mr. **Hood**. I think all is not well. We need a totally new system.

Fifteen days and nineteen days does not square up with anything I have heard. The lowest I heard on a bill was 33 days, and it is still running 40 days and 60 days and more.

Senator **Percy**. Has the task force the Governor set up with the IDPA, the special unit, is it a good organizational approach?

Mr. **Hood**. No.

Senator **Percy**. And finally, if Illinois has in fact improved in any degree its utilization review system, how then can the abuses which you have pointed out still continue to occur and why?

Mr. **Hood**. I do not think that review system is working. As the Governor's task force is occasionally referred to by his own officials, as the official coverup, then I do not see it working.

Senator **Percy**. I want to thank you very much indeed for your testimony, and, again, Mr. Chairman, and, Senator Muskie, thank you for your courtesy.

Senator **Muskie**. Thank you. You are certainly welcome, Senator Percy. That was most appropriate that you had been able to get into the situation.

Mr. Hood, there can be no doubt in the minds of anybody listening to you, reading your statement, listening to Senator Percy's questions and your answers, which you described, that it is a mess of the first magnitude.

Mr. Hood. Exactly.

Senator Muskie. Let me ask you this. It is inconceivable to me that the practice is associated with this factoring industry, as you have described, and must be an open book to those State agencies, which are involved, is this not so?

State Employees Help Factorers

Mr. Hood. It is so, Senator Muskie. They allow the employees of the department which handled medicaid billing to work with the factoring companies, and these employees prefer it that way, because the factoring companies get to know them, they give them gifts, and in fact, they do perform one service sometimes, and they do perform the codes, the doctors are not as well trained as they should be, they do not know all of the proper codes, in filling out the medicaid forms.

The factoring firms do attempt to alleviate this problem, for one reason, I think the clerical rank-and-file hike them.

Senator Muskie. There must be widespread understanding, even among those that are employed and the higher officials that this sort of thing is going on.

Mr. Hood. Exactly. The situation is known in other State departments, it is generally considered to be a terrible situation in the State of Illinois by people knowledgeable.

The problem is it is not the subject, even with the newspaper coverage given it, that is, it affects the great places. The doctors hate the system. Most people in government think the system is corrupt, and they are correct, and the only people that like the system are the factoring companies and the few people they are greasing.

Senator Muskie. Does anyone in the State government assume any kind of responsibility with respect to eliminating the practice, or of changing the system? I mean, does it just go on as an open book, and no one at all is interested in doing anything about it?

Mr. Hood. That appears to be the rule. There is a special task force set up by the Governor of our State. He has hired some lawyers to look into it, and the final report calls for no indictments, no moneys recovered. The Federal investigators, who have been looking at the same material—the GAO, the FBI—reportedly think that the State task force has done nothing but coverup, get in their way, and tried to hide evidence.

Senator Muskie. Are the Federal agencies involved aware of the magnitude as you describe here?

Mr. Hood. I think they are. I was told yesterday by a person who has been meeting with this task force, the Federal task force, that they think there may be some Federal indictments very soon out of this.

Senator Muskie. How long have they been digging into it?

Mr. Hood. They have been digging into it almost 11 months.

Senator Muskie. Now, you have said something like $65 million a month in payments through the Illinois agencies. What proportion of those payments are subject to this factoring system?

Mr. **Hood**. Senator, we have not been able to pin that down. I would say the proportionate amount is not terribly high. We think may be $25 or $30 million is going through the factoring system in a year, figuring about 15 percent of that has been taken out.

The problem is, this is a brand new industry. There was almost a new factoring company starting every month for the last 24 months in the State of Illinois, and the legislation will give them their own licensing board. With this there will probably be even more of these factoring companies.

COMPETITION HIGH

One of the greatest problems these factoring companies have is too much competition. One of the factorers asked all of the inside details about the factoring business, he said he did not want to tell him anymore, because the last guy that interviewed him, ended up going into competition.

Senator **Muskie**. But there is not enough competition to drive the rates down, not yet.

Mr. **Hood**. They have all got their corner of the market.

Senator **Muskie**. So some State employees find this system useful. What is your own judgment, is it the system, does it have enough utility, that you ought to try to preserve it in some way, protect it, or just prohibit it? Is it so corrupt, that it ought to be prohibited, or should it be licensed and subject to some kind of scrutiny?

Mr. **Hood**. That is a good question. One, I do not think it is necessary, but if we will accept in the alternative as it is, it should be put under the most stringent controls with access to the books and records of these factoring firms, which is what they have been trying to avoid. The service they provide is not really needed. If we have a prompt and rapid system of payment, it will not exist much longer.

Very few doctors—who are medical providers I have come across—would have difficulty in obtaining short-term loans at a bank, if there is only a 30- or 60-day cash flow problem. The problem that started it all was it was taking a year to get paid.

Senator **Muskie**. Is that a problem that could be that easily solved, the question of expediting the bureaucratic practice, can it be done?

The Social Security system is having great difficulties now with the SSI payments. A lot of those are being processed manually, a lot of those are being delayed, and there are questions as to the percentage of error, and the rest of it somehow going through that system which is about efficient a system of paying out money as the Government has yet put together.

Mr. **Hood**. I would look past social security, and look at our neighboring State of Michigan, which has a very fine system, which they put in several years ago, before they had the high level of medicaid payments that they have now, which even now is less than Illinois.

They have a modern computer system, with modern equipment, they have optical scanners, everything set up so it does not have to be done by hand. They have a very low reject rate. They have a very low rate of mistakes, and they get their payments out extremely rapidly.

I think if we had the Michigan system in Illinois, we would get rid of all of the factoring companies overnight.

Senator MUSKIE. From my own experience, doctors are very poor bookkeepers or paper shufflers. Some of the delay may be attributed to that fact, of sloppy accounting practices on the part of the doctors.

They do lean on the factors to some extent to perform bookkeeping or accounting functions, could that not be so?

PHYSICIANS GET AID IN BOOKKEEPING

Mr. HOOD. I have had a number of doctors indicate that they are not the best businessmen nor the most careful accountants in the world. They do lean on their own staff and factoring firms to do a lot of that work for them.

Senator MUSKIE. So they charge off some of this fee, which would be normal overhead processing their bill?

Mr. HOOD. It is sort of an understood part of the system. Maybe we should state it for the record, that when these doctors are paying 12 percent and more into the factoring firms, they stand to lose even more, because some bills will be rejected by the medicaid system, they just up their bills to cover their contingency, and in the end, you and I, and the Federal budget will pay for that.

Senator MUSKIE. That is the next point I wanted to raise. Up to this point, the testimony has indicated this is coming out of the hide of the doctors, but I would doubt that would happen.

The doctors will pass that on to somebody else, and you say that is what is happening?

Mr. HOOD. Exactly. The doctors are passing it through the system. There are some cases where doctors have been terribly strapped. The only question is not getting money. It is just that they are not getting what they would like to get. I think the whole problem is the ultimate extra cost to the medicaid system. Looking into the future, if you are talking about national health care, and whatever kind of system you have for payments there, are you going to have factoring on a nationwide scale, or through whatever State systems are set up? It is a very serious problem, and you can see from several years of experience in Illinois, how bad it can get.

Senator MUSKIE. Let me ask you this, looking down the road, this thing had developed in the early years—leeches have a way of finding these kinds of programs—and yet there are elements of futility here that might make it difficult to eradicate this. The fact that many, many doctors have a high proportion of their income in these programs, the fact that there is law and paperwork involved, difficulty collecting, and even the most expeditious kinds of processing by bureaucracies, there will be delay.

There will always be some pressure for this kind of service among providers for health care, is not that correct?

Mr. HOOD. In those strict terms you put it, there might be a need for a small amount of factoring.

Efficient Delivery System Needed

There are some doctors and laboratories which do have a high percentage of medicaid patients; however, I still think an efficient delivery system, a payment system that only took 30 to 45 days, which did not cause any sort of serious cash flow problem, and the amount of interest these people are really paying is pretty high compared to what they get in a bank.

Senator Muskie. Thank you very much.

You have rendered a real public service.

Senator Moss. Thank you very much, Mr. Hood, for your interesting and stimulating testimony about the factoring system.

I think what Senator Muskie was getting at, that doctors oftentimes did not have any very efficient bookkeeping system is a part, however, it seems to me, as I have observed, that many groups of doctors now go together and have a central bookkeeping system and that they also build up reserves in their clinic, or whatever their association is, so that perhaps the pressure of the cash flow is not as extreme as it might be on an individual doctor who just depended on collecting his bills month by month.

Mr. Hood. That is sort of the coming trend. I would add to your comment, which sparks another suggestion. They started to put in Illinois, and never really made it, was a self-bonding system. That public aid, whatever the payment system is, medicaid would pay 80 percent to any doctor, would pay 80 percent of his bills, keep 20 percent in reserve, and they would process them later, and work out any differentials of claims, figuring that the 20 percent would be far more than necessary for most doctors, and that was another fairly good system that could be worked out.

Senator Moss. Well, thank you very much for your fine testimony, and if the factors and others hear about this, and want to write to the committee, tell their side of it, we will hear whatever they have to say.

Senator Muskie. Do you expect to be flooded with mail?

Senator Moss. I do not think so, after what we have heard.

We do thank you.

Mr. Hood. Thank you.

Senator Moss. We will now hear from William Crawford, reporter, *Chicago Tribune*, Chicago, Ill., and William Gaines, reporter, *Chicago Tribune*, Chicago, Ill.

Mr. Crawford, you may go ahead, unless you have some arrangement between the two of you as to who goes first.

STATEMENT OF WILLIAM CRAWFORD, REPORTER, CHICAGO TRIBUNE, CHICAGO, ILL.

Mr. Crawford. Thank you, and good afternoon.

I am here today to tell you about my experience as a medicaid patient at Northeast Community Hospital which in 1974 took in more than $2 million in public aid funds.

I was admitted to Northeast without being examined by a doctor and spent 5 days there being treated for pretended alcoholism even though I was perfectly healthy. The hospital billed the Illinois Department of Public Aid $394 for my stay.

I was taken to the hospital in a private ambulance even though I was ambulatory and had sufficient funds in my back pocket to take public transportation or a cab to the hospital for one fraction of the cost of an ambulance. The ambulance company billed the Illinois Department of Public Aid $69 for the trip, $45 to pick me up and $1.35 a mile thereafter.

During my stay at the hospital, my doctor visited me four times for a total of 10 minutes. That particular doctor routinely bills public aid $10 for each such visit. In total, my stay at the hospital and my ride there would have cost the taxpayer more than $500.

The fact that I, a perfectly healthy person, was able to spend 5 days in the hospital at a cost of more than $500 to the taxpayer, and be admitted to the hospital without examination by a doctor, and get a ride there in a private ambulance—even though I was ambulatory—and had the money to get there by my own means, raises serious questions about the hospital's admission policies.

The squalid surroundings of the hospital and the substandard, dehumanizing medical care it offers its patients raises even more serious questions about the continued functioning of the hospital.

SUBSTANDARD CARE AT NORTHEAST

Before getting into what I saw during my stay at Northeast, the bizarre treatment I received, and the convoluted manner in which I was admitted, I would like to make mention of those factors which caused us to commit ourselves to an investigation of the hospital in the first place. Believe me, we were not singling out Northeast Community for criticism unnecessarily.

As far back as a year ago, a registered nurse who has since resigned from the hospital, came to us with wide-ranging complaints about the filthy conditions of the hospital and the substandard medical care accorded its patients.

More recently, a second employee, who worked at the hospital as an intake counselor, came to us with even more damaging allegations. She echoed the sentiments of the registered nurse about the filth, and squalor, and neglect of patients, but then went even further.

She accused the hospital of engaging in a wholesale ripoff of the medicaid program. She claimed the hospital actively recruited patients from the rundown areas of the city by setting up informal agreements with owners and managers of hotels and flophouses in which large numbers of welfare recipients resided.

According to these informal agreements, if a welfare recipient came into the lobby of his hotel in an unruly state, from too much alcohol, for example, the hotel manager would alert the hospital and if the hospital had a bed available, it in turn would call a private ambulance to bring that person to the hospital.

She claimed the hospital actually employed a counselor full time who had his own office in one of these flophouses, namely the La Salle Plaza Hotel, located on the fringe of a skid row neighborhood. His real job consisted of driving around the streets, encouraging welfare recipients to come to the hospital for a rest and offering them a ride there.

We began to take a closer look at Northeast by setting up a surveillance of the hospital, logging ambulance company trips to and from the hospital, and by examining certain documents and questioning former patients and ambulance drivers.

Soon it became clear that the largest number of persons being admitted to the hospital by private ambulance were coming from three large tenement houses located in different parts of the city and occupied almost exclusively by welfare recipients.

Records show, for example, that in one 6-month period, more than 100 patients were taken to Northeast from one of these buildings, the Northmere Hotel located a couple of miles from the hospital.

On one occasion, we watched two men walk from the hospital to a waiting ambulance where they were driven to the Northmere Hotel.

When questioned, the ambulance company said it was asked to make the trip by the hospital and explained one man was treated there for a head injury and the other for alcoholic rehabilitation. When asked why the latter needed an ambulance, the company told us it wasn't quite sure but "guessed it was hospital procedure."

Former patients of the hospital located all over the city told us how they or the hotel manager customarily called an ambulance when they decided they wanted to go to the hospital. An ambulance driver told us: "Once they get a green card, they think they can use us like taxicabs."

With these initial facts, we became increasingly convinced that further investigation was justified.

GETTING ADMITTED TO THE HOSPITAL

We decided the best way in which to get a firsthand look at Northeast would be by getting admitted to the hospital as a patient, an assignment which eventually devolved on me.

However, because the hospital relied almost entirely on welfare recipients for its patients, it was clear that I would have to first obtain a medical assistance card from the Illinois Department of Public Aid.

With the approval of a State legislative committee investigating welfare fraud in Illinois, I applied for a medical assistance card from the IDPA. After three trips to the public aid office over a 6-week period and much bureaucratic wrangling, I finally received the card.

With the green card in hand, I then booked a room at the La Salle Plaza Hotel where the counselor from Northeast was alleged to have his office. I might at this point say I never personally ran into that individual.

Little did I know that less than 24 hours later I would be lying on a second floor bed of Northeast Community Hospital even though I was in perfect health and had not even been examined by a doctor.

I turn now to a chronological narrative dealing with my stay at the hospital and beginning with my booking a room at the La Salle Plaza Hotel.

At 3 p.m. on July 14, I entered the hotel and booked a room with Hank Rholand, the hotel desk clerk and himself a former patient of

Northeast Community Hospital. After I paid for the room and made certain Mr. Rholand saw my green card, the following dialog ensued.

"Yeah" he told me, "three guys came in today and said they were sick so I made reservations for 'em at the hospital and shipped 'em out. Anytime you're feeling sick you just let me know and I'll call the hospital and make reservations for you. You just let me know when you're sick and I'll make the reservations and have an ambulance down here to give you a lift to the hospital."

I told Mr. Rholand I wasn't feeling up to snuff and asked him if I could get to the hospital without the green card. He told me, "You got to have the green card, otherwise there's nothing I can do for you. You got to have the green card."

. I handed Rholand my green card, followed him back to the desk where he picked up the telephone and called the hospital. "This is Hank from La Salle Plaza," he told the hospital, "I would like to make a reservation for one Crawford, William, for 9:30 in the morning."

Rholand then entered my green card number in the hotel register and placed my card in my mailbox, assuring me that everything was all set and an ambulance would be there the following day to pick me up. I was about to leave the hotel when Rholand, apparently apprehensive he would lose a customer, asked me if I was going out to get a jug of wine. I told him I was, at which point he said, "Save you the walk. You wait right there."

WINE SUPPLIED TO "ALCOHOLIC"

Unbelievably, Rholand exited from his office, went into an adjacent room, and returned moments later with an ice cold jug of inexpensive wine. "Here you go, Bill," he said. "You take this to your room and have a good time."

Incidentally, he was to repeat that utterance the following morning, as I was waiting in the lobby of the hotel for the ambulance to arrive. He supplied me again with a free bottle of ice cold inexpensive wine.

The following morning, at about 11 a.m., July 15, the private ambulance arrived with two attendants aboard.

They ushered me out of the hotel into the ambulance* and after a comfortable ride sitting up chatting with one of the attendants, I arrived at the hospital some 15 miles north of the hotel. I told the attendant on the way to the hospital I was suffering from slight stomach pains. Yet, when the ambulance company submitted its bill to public aid, it listed me as an emergency case and described conditions of a heart attack. Furthermore, their bill to public aid stated I was suffering from acute abdominal pains, chest pains, and having a difficult time breathing.

Apparently, the ambulance company felt compelled to alter its records to guarantee payment for the trip to Northeast.

Moreover, under IDPA regulations, the ambulance company is compelled to take emergency cases to the nearest hospital. In my case, the ambulance chose instead to take me to a hospital some 15 miles away and, I might add, at the rate of $1.35 a mile. On the way, we passed literally dozens of other hospitals.

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*See photograph, p. 62.

LA SALLE PLAZA
HOTEL
873
LaSalle Plaza Hotel
AMBULANCE

At this point, this is a map,* and it is a wedge of Chicago that runs north up along the lake, and it is on this side of the red circle, approximately where the hotel from which I was taken is located.

The hospital itself is up here, representing a distance of perhaps 15 miles or so. However, I would like to point out, these black dots represent hospitals which I could have been taken to, and are closer than Northeast from the La Salle Plaza Hotel.

I would like to make special reference to Henrotin Hospital, which is located less than 100 yards from the hotel. I could have walked there—I could have crawled.

Without talking to a doctor, nurse, or other medical personnel, I walked with the ambulance attendant to the switchboard in the front of the hospital to drop off my green card.

The switchboard operator told me my room number and I climbed the stairs with the attendant to the second floor. There, the attendant escorted me to my room and bade me farewell.

I was now a patient at Northeast.

RECORD OF SYMPTOMS FALSE OR EXAGGERATED

Though I was chipper and alert and complained only of slight stomach pains, hospital records show that I was, and I quote: "a patient admitted because of nausea, vomiting and epigastric pain . . . Extremities: tremulous."

These are all symptoms of a person going through withdrawal.

The tentative diagnosis: gastritis and duodenitis, two ailments which are commonly associated with chronic alcoholism and which are the most frequently listed admitting diagnosis on Northeast's public aid records.

I have a copy of the photograph of the bill, part of a bill submitted to public aid for payment, and it shows the diagnosis as I just indicated.

I will submit this for the record at this point.**

It says: "Final disposition on discharge, advised to go to nearest health center," which is not true, "to be followed as an outpatient, or to make an appointment."

I was never advised of that either. The final diagnosis by my doctor was acute alcoholic gastritis, and on public aid records the discharge diagnosis was alcoholic addiction.

Again, both the hospital and doctor apparently felt compelled to alter the records in order to be assured of getting their money from public aid.

The care I received in the hospital was bizarre, to say the least. My doctor was notified by telephone of my admission and from his desk at a board of health clinic, he placed me on an intense program of vitamins, prescription tranquilizers—including Librium and Dalamane, and Dilantin, an anticonvulsant often used to control epileptic seizures.

Health experts have told us it is totally inappropriate for a physician to order these drugs over the phone for a patient he has

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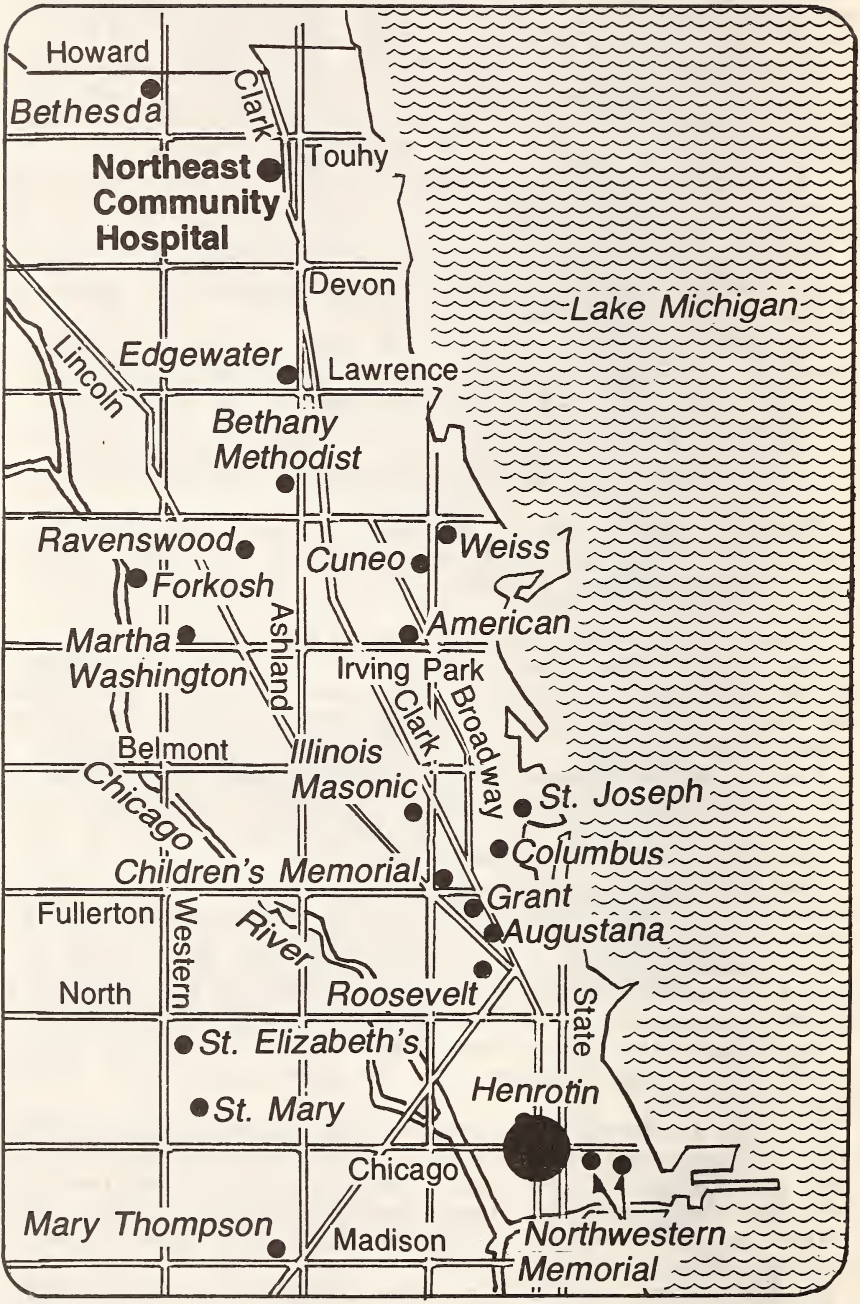
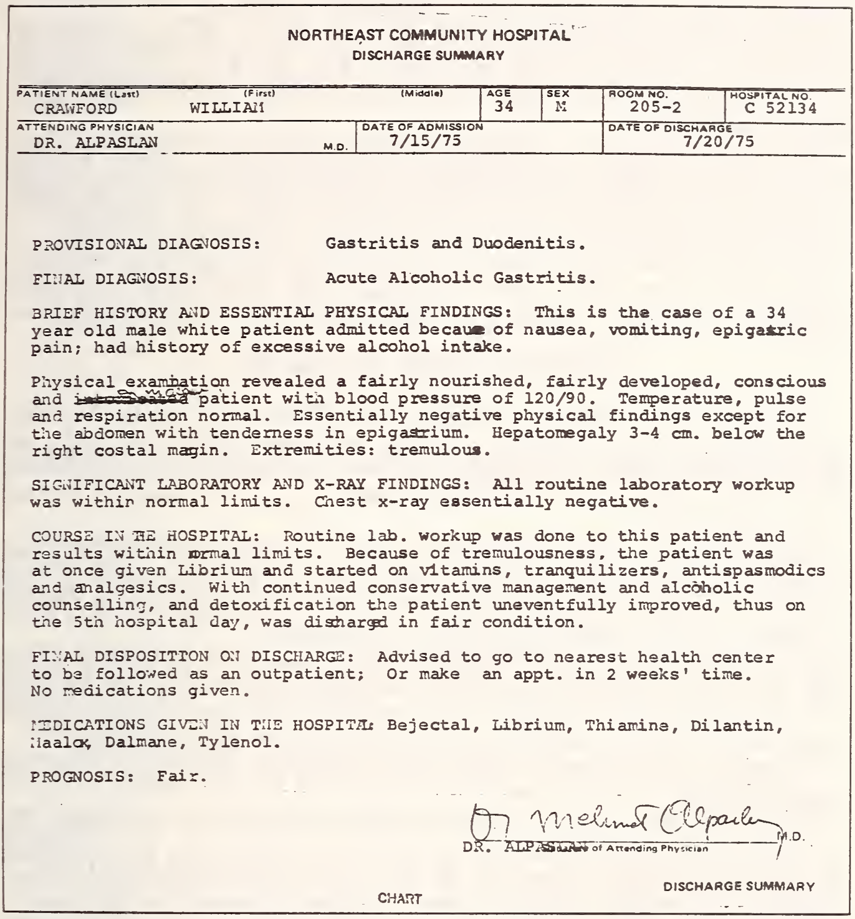
*See p. 64.

**See p. 65.



Chicago Tribune Task Force report



NORTHEAST COMMUNITY HOSPITAL
DISCHARGE SUMMARY

PATIENT NAME (Last)	(First)	(Middle)	AGE	SEX	ROOM NO.	HOSPITAL NO.
CRAWFORD	WILLIAM		34	M	205-2	C 52134

ATTENDING PHYSICIAN	DATE OF ADMISSION	DATE OF DISCHARGE
DR. ALPASLAN M.D.	7/15/75	7/20/75

PROVISIONAL DIAGNOSIS: Gastritis and Duodenitis.

FINAL DIAGNOSIS: Acute Alcoholic Gastritis.

BRIEF HISTORY AND ESSENTIAL PHYSICAL FINDINGS: This is the case of a 34 year old male white patient admitted because of nausea, vomiting, epigastric pain; had history of excessive alcohol intake.

Physical examination revealed a fairly nourished, fairly developed, conscious and ~~intoxicated~~ [illegible] patient with blood pressure of 120/90. Temperature, pulse and respiration normal. Essentially negative physical findings except for the abdomen with tenderness in epigastrium. Hepatomegaly 3-4 cm. below the right costal magin. Extremities: tremulous.

SIGNIFICANT LABORATORY AND X-RAY FINDINGS: All routine laboratory workup was within normal limits. Chest x-ray essentially negative.

COURSE IN THE HOSPITAL: Routine lab. workup was done to this patient and results within normal limits. Because of tremulousness, the patient was at once given Librium and started on vitamins, tranquilizers, antispasmodics and analgesics. With continued conservative management and alcoholic counselling, and detoxification the patient uneventfully improved, thus on the 5th hospital day, was discharged in fair condition.

FINAL DISPOSITTON ON DISCHARGE: Advised to go to nearest health center to be followed as an outpatient; Or make an appt. in 2 weeks' time. No medications given.

MEDICATIONS GIVEN IN THE HOSPITAL: Bejectal, Librium, Thiamine, Dilantin, Maalox, Dalmane, Tylenol.

PROGNOSIS: Fair.

Dr Mehmet Alpaslan M.D.
DR. ALPASLAN Signature of Attending Physician

CHART

DISCHARGE SUMMARY

not even seen. Only in an emergency case should such drugs be ordered by phone and then they should be mild doses.

But these doses were not mild, experts say "these drugs may be normal for a person going through D.T.'s, we were told, but not for a normal person. Others likened the medication to using a shotgun to shoot a fly.

My doctor told me I could go at the end of the 5-day stay, the maximum time public aid will pay for detoxifying alcoholics. Before I could even vacate my room, I was not even out of my bed, another patient had been admitted to the hospital and assigned my bed.

During my 5-day stay I never saw an alcoholic treatment counselor. I was never asked why I was drinking. I was never asked what sort of help or support I needed to kick my supposed dependence on alcohol.

Therapy Sessions Inadequate

Instead, I was offered a daily, 45-minute long group therapy lecture given by a reformed alcoholic who was being paid $3.05 an hour—tops at Northeast—for his efforts. The sessions were optional, and of 100 patients in the hospital, only about 10 cared to attend these sessions.

The only other planned activity during my stay was occupational therapy, an hour long exercise supervised by an untrained young woman in a small, ill-equipped room where we fumbled about trying to make ceramic ashtrays and other bric-a-brac.

I asked the young lady conducting the session, if I could make a key chain. She explained to me that she only had 1 needle for perhaps 10 patients who had come to these sessions, and that another fellow was using it, and I would have to try to thread the key chain.

Northeast, incidentally, billed public aid $4 per person, per day for these sessions.

While the Northeast alcoholic treatment program is a sham, its facilities and staff for alcoholic patients are just as bad. The building is poorly maintained, showers do not work, cleanliness is an afterthought, and nurses and aides often ignore the needs of patients.

During my stay I killed 16 cockroaches in my room. When a nurse dropped a pill on the floor, a nurse picked it up and handed it back to me, ordering me to swallow it. When I complained I didn't have a fork to eat dinner, an aide simply took a used one from the plate of another patient, rinsed it clean, and handed it to me.

On some days the hospital ran out of fresh sheets, gowns, and pillow cases, and I was once issued a soiled gown to replace the one I had on.

Those patients with real medical problems received little attention from the nurses, who increasingly smoked around patients and spent much of their time in my room watching TV soap operas.

"I never go in there unless I have to," one nurses' aide told me, pointing to the room of a man in isolation with festering sores on his legs, "I'm not going to catch that stuff."

My fellow patients were often reduced to orderlies themselves, supplying those in isolation with coffee, cigarettes and water and other needs because no one else cared to.

One night, a toilet overflowed in a room with four patients, spreading water mixed with human waste across the floor. The stench filled the room and began to seep into the hallway, but no hospital personnel came to assist. One of the men had to mop it up himself.

An hour later, the toilet overflowed again. An old man, equipped with a walker, shuffled aimlessly through the stinking mess, but no hospital staff member was around to stop him. The mess remained on the floor for 1 hour before a janitor cleaned it up.

Said Michael Creed, a three-time patient at the hospital: "They treated everyone like animals."

That is the end of my statement.

Senator Moss. Well, that is an astounding statement, and conditions that exist like that are almost unbelievable.

I would like to ask Mr. Gaines if he could give his statement, and then if we have questions, we will ask either one of you.

STATEMENT OF WILLIAM GAINES, REPORTER, CHICAGO TRIBUNE, CHICAGO, ILL.

Mr. Gaines. When the Chicago Tribune Task Force began an investigation of hospital care, one hospital soon emerged as needing special scrutiny.

It was Von Solbrig Hospital, an 83-bed facility in a white, middle-class neighborhood of Chicago. The hospital is unique in Chicago because it is the only general hospital in the city that has profit-making as its expressed purpose.

Its founder and sole owner is Dr. Charles von Solbrig, who is also the administrator, medical director, and chief surgeon. He controls every facet of the hospital operation. He conducts surgery without fear of criticism of any hospital board that he does not control.

The board of health of the city of Chicago, which is empowered to enforce State regulations on the licensing of hospitals, would make routine inspections, carrying a checklist of possible sanitary violations. The fire department inspectors would check fire extinguishers and doors and the like.

But no one was judging the amount of medical attention given a patient for the seriousness of his illness or the dollar charged. And no one was asking whether the hospitalization, length of stay, or operation was necessary.

A hospital surveillance program set up several years ago in Illinois to monitor medical decisions in the use of public welfare money did not check on Von Solbrig Hospital. The hospital was judged too small for that.

Professional medical organizations would not be critical of doctors. We found that no doctor would go on the record as critical of another doctor. And when a lay person complained, doctors would say: "Who are you to criticize? You're not a doctor."

"Nurses Doing the Job of Doctors"

So I got a job as a janitor in Von Solbrig Hospital and I found that I didn't need to know anything about medicine to know that something was wrong. All I needed was to count the staff in the surgery area, patient wards, and the emergency room. I found that nurses were doing the job of doctors. Nurses aides were doing the job of registered nurses. And I, as a janitor, would do the job of orderly, aide, and nurse.

There was no doctor specifically assigned to the emergency room. On some days, the only physician available to the entire hospital was the radiologist. There was no specialist in pediatrics or geriatrics available although patients ranged in age from infants to octogenarians. The short staffing of the surgery suite was the most shocking.

Many times, the only doctor in the hospital would be in surgery, performing one operation after another. Assembly line operations were performed on children on public aid.

The recovery room would either be bypassed entirely or an untrained aide would be placed there to awaken a patient after surgery and remove him to his room.

One aide inside the surgery room was a 16-year-old high school student who volunteered to work in the hospital and was assigned to the surgery room within 4 days and without any training. His duties included counting sponges to see that none were left inside the patient.

Later, I would be called into the surgery room to help move patients off the table during a week when the high school boy was home with the measles. It didn't matter that moments before I was to be called into the surgery room, I was mopping floors or unloading a truck in the parking lot and wearing my dirty janitor outfit.

Every day I would help lift elderly patients between janitor jobs. One elderly medicare patient was in a cast and an aide, the teenaged volunteer and I struggled to lift her in and out of the bed as she cried out in pain. None of us had any training in handling patients and the hospital had no mechanical lifts.

Although bare necessities only were provided, medicare and medicaid payment would be high because of unneeded surgery and numerous extra charges. The meaningless recovery room charge was $13, tests were taken on all patients, including $19 for cardiograms on infants. One doctor who brought his patients to Von Solbrig Hospital, specialized in mass tonsillectomies. He runs a clinic in the black ghetto area of Chicago's West Side. His patients told us that they were herded into his office "like cattle . . . lined up, and their throats peered into for a second or two."

Unnecessary Tonsillectomies Performed

The diagnosis would be tonsillitis—for entire families, sometimes with five or six children. Medical experts told us that chances of an entire family of five needed a tonsillectomy the same day are astronomical.

This one doctor, Edward J. Mirmelli, was doing more tonsillectomies in 1 day than six doctors performed in 1 week in Cook County Hospital's ear, nose, and throat clinic.

A mother of six was told that all of her children must have their tonsils out, and when she protested, the doctor told her she didn't love her family if she didn't have their tonsils out. She answered that her children never had colds or sore throats and she refused to send them to the hospital where the doctor had already scheduled their surgery. Other families put blind trust in their doctors and there was a continual flow of tonsil cases from the ghetto.

Here is a picture of the surgery book* on a day in which a welfare family of five was operated on. Within a month, another family of five was brought in. This combination of unneeded operations and dangerous understaffing to cut costs in a for-profit hospital reached a climax in my experience at the hospital . . . when two sisters were operated on consecutively for both tonsils and hernias. The first child, 8 years old, had been left in the recovery room with an untrained aide while the surgery crew operated on the second child.

State law in Illinois requires that a registered nurse be in the recovery room and a doctor release the patient because the vital signs must be monitored after surgery to insure that the patient does not aspirate blood.

The aide was unable to awaken the child and she had to interrupt surgery to get help to force air down the child's throat. Then the child was returned to her bed, the next operation concluded on the 6-year-old sister, and I, the janitor, was left to watch the child in the recovery room.

It was with this kind of assembly line surgery that the doctor was able to bill medicaid for $124,000 in 1 year. In 1 day, he saw more than 100 patients in his office.

Now the Chicago Board of Health, Illinois Board of Health, and Illinois Public Aid Department have started investigations into the hospital and the doctors who practice there.

After our stories appeared, we were told many people took relatives, who were private patients, out of the hospital, but those who remained were mostly medicaid or medicare patients.

I appreciate the opportunity of speaking before the committee and I would like to answer any of your questions. I would be happy to answer any questions.

Senator Moss. Thank you very much for your statement. It, too, is an astounding statement, as the one that went before by Mr. Crawford. It hardly seems possible that these conditions could exist.

You said you thought that Von Solbrig Hospital was one that should be examined. How did you come to that conclusion?

MONETARY INTERESTS IN VON SOLBRIG

Mr. GAINES. It was during our investigation, that we learned about the hospital, and we had heard about the hospital, and the fact it was a profitmaking hospital made it unique in the city, that the persons who had control over the hospital length of stays there also had a monetary interest, and a monetary interest in long stays and possibly unnecessary surgery.

Senator Moss. On these family surgeries of five children, did you talk with members of the family, the mother and the father of any of those?

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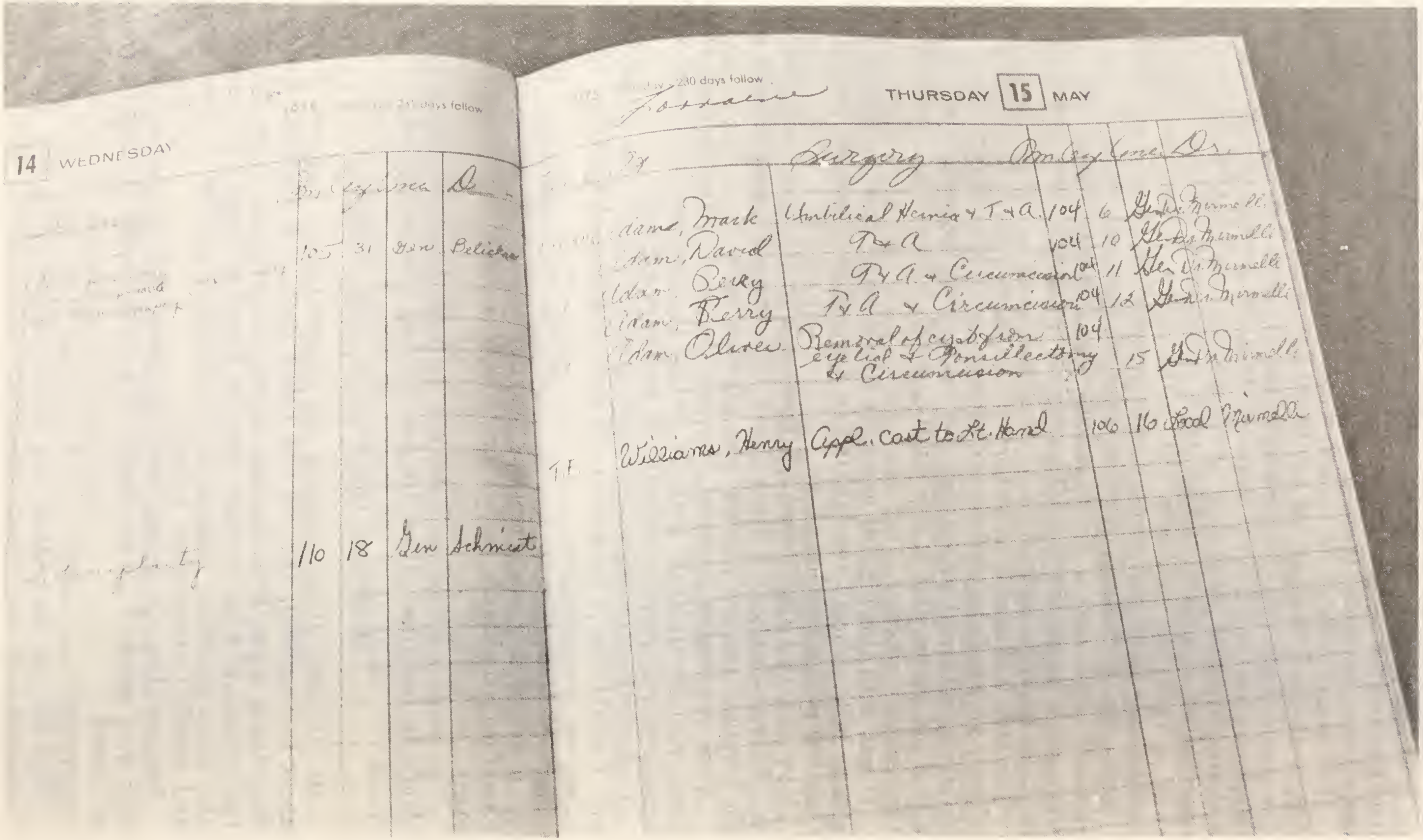
*See p. 70.



14 WEDNESDAY

... 231 days follow

Rm	Age	Anes	Dr.
105	31	Gen	Belicka
110	18	Gen	Schmidt

... 230 days follow [illegible]

THURSDAY **15** MAY

Pt	Surgery	Rm	Age	Anes.	Dr.
ams, Mark	Umbilical Hernia & T & A	104	6	Gen	Dr. Mirnelli
am, David	T & A	104	10	Gen	Dr. Mirnelli
am, Perry	T & A & Circumcision	104	11	Gen	Dr. Mirnelli
am, Berry	T & A & Circumcision	104	12	Gen	Dr. Mirnelli
am, Oliver	Removal of cyst from eyelid & Tonsillectomy & Circumcision	104	15	Gen	Dr. Mirnelli
Williams, Henry	Appl. cast to Lt. Hand	106	16	Local	Mirnelli

Mr. Gaines. Yes, we did; we talked with as many as we could find.

Senator Moss. And was this on the recommendation of the doctor, that all of this occurred, or how did they get five of them in a row?

Mr. Gaines. Well, the symptoms for tonsillitis are sore throat, loss of hearing and high fever, and we found that when patients were, a child was brought in by his mother into the clinic, he might just have had a sore throat, he might not have had the other symptoms, and that the other members of the family did not have those same symptoms, but the mother was asked to bring in the other members of the family, and have them examined, and then the diagnosis would be tonsillitis for the entire family.

The mothers who brought their children in felt that the doctor was concerned, because he asked them to bring in their other children.

It seemed to them he was doing his job, and they would trust in him when they brought them in, and although the governing authorities did not find out about these mass tonsillectomies, when I first started at the hospital, I found out that even janitors there were aware that something was wrong.

The first day I worked there, the other janitors told me that entire welfare families were being operated on for tonsillitis.

They told me if I still had my tonsils, to keep my mouth shut.

Senator Moss. I would think that would be good advice. I would have kept mine shut too. From time to time, we have had allegations that doctors do that, that is to say, the mother arrives with a sick child, accompanied by other children, the doctor examines all the children, and he bills medicaid for all of them. Have you encountered this?

Mr. Gaines. Yes, we did; entire families were encouraged to come in at the same time, and be examined in the same room, and perhaps 2 minutes were spent with each family member.

Senator Moss. It was Mr. Crawford who said that a doctor visited him 4 times for a total of 10 minutes, and then each one of those were $10 a visit.

Was there here something akin to that, each one would get a visit, and get the full billing, for each child, is that correct?

Mr. Gaines. Yes, it would be full billing for individual office examinations, for each child and adult in the family.

Senator Moss. Mr. Crawford, you mentioned in your statement about someone at the LaSalle Plaza, who had a van, and solicited patients for the hospital. Could you expand on that a little bit for me?

PATIENTS SOLICITED FOR HOSPITAL

Mr. Crawford. Senator, you can go to the 500 block of North Clark Street, in Chicago, an area commonly described as skidrow. You can ask just about anyone who appears to be a frequenter of that area, if he has seen a fellow by the name of Jim Zimmerman, and invariably, you will evoke the response, "Wait long enough, and he will show up in his red van, and you can talk to him, or go to the LaSalle Plaza Hotel, he has offices there."

We were never able to substantiate that Mr. Zimmerman had offices at the LaSalle Plaza Hotel. Everybody connected with the hospital denied it. But during a labor hearing last winter, during a NLRB hearing in the Federal Building, Mr. Zimmerman was called to testify. We examined the transcript of that hearing, and in it, Mr. Zimmerman openly admits to the hearing officer that he in fact was a full-time employee at the hospital, who had his offices at the LaSalle Plaza Hotel.

We tried to interview Mr. Zimmerman, but he would not talk to us. Everybody we talked to in the area of North Clark Street, who had been in the hospital time and again, told us that Mr. Zimmerman would give him a ride up there.

Senator Moss. Well, Mr. Rholand, the clerk that signed you in when you first went there, and provided the wine, et cetera, every implication is that he was getting a kickback from the hospital in some way.

Did you ever trace down the amount, or how the money passed, or anything of that sort?

Mr. Crawford. No, sir; if there were any activity of that kind, we weren't able to substantiate it.

We were unable to make any case in that direction. The heavy traffic of the ambulances, carrying patients from the same hotel to the same hospital, day in and day out suggests that kickbacks were being used routinely. But we were not able to prove that.

Senator Moss. In your visit to the hospital, did you find that they had large numbers of elderly patients?

Mr. Crawford. By far, the majority of the patients in that hospital were of an age that would be called elderly.

Senator Moss. And you have reason to believe that perhaps they had been solicited, each as you had been solicited, much as you had been solicited to go there?

Mr. Crawford. I do not think there is any question about it. I met these people from all over the city of Chicago, and they had arrived at the hospital by passing through the same conduit as I.

Senator Moss. The only ticket in is the green card?

Mr. Crawford. That is the big item. If you had the green card, you could get an ambulance ride to the hospital from anywhere in the city. People from the far south side, 200 blocks from the hospital could get a ride to Northeast if they had their green card. All they had to do was to get on the phone and call up an ambulance company operating in the area, and they could get a ride up there without seeing a doctor.

Senator Moss. What ambulance is this, is this a small car converted to an ambulance?

Mr. Crawford. Mr. Zimmerman's van?

Senator Moss. Yes.

"$10 a Head" for Referrals

Mr. Crawford. Mr. Zimmerman confined his activities pretty much to the North Clark Street area. But private ambulances took over that function in all other areas of the city.

It was rumored that Mr. Zimmerman was getting $10 a head for every person he brought in from the Clark Street area.

His sphere of activities was pretty much confined to Clark Street, and after that, it was other ambulance companies. If you had the green card, and you wanted to go to Northeast, he would be more than happy to drive you up there.

Senator Moss. Mr. Gaines, you described the duties you were called on to do when you were the janitor there. Tell us, did you have to put a smock over you or anything at all, or did you just go into the recovery room in the regular old clothes?

Mr. Gaines. I walked into the recovery room and the surgery room wearing the same janitor clothes that I had just worn to mop the floor, and unload the truck in the parking lot. I had dusty shoes. I was called in by the nurses for their help, to help move the patient over off the table onto the cart, in the surgery room.

Senator Moss. Still wearing the old clothes?

Mr. Gaines. Yes.

Senator Moss. Marcus Welby would like that.

Well, your stories are so shocking that it is hard really to comment on them.

Are these just very outstandingly bad situations, or are there others out there in that area like this, or similar, let's say?

Mr. Gaines. I think we found these as examples. There may be others with the same stories that could be told. We don't know. We did not set out to show a broad picture. We set out to show examples of what might happen.

Senator Moss. Would it be your idea that this could be rectified by the State, or is there anything that the Federal Government ought to do to deal with the situation like this?

Mr. Gaines. We laid out the story for our readers with the hope that they would draw a conclusion, and that the governmental agencies responsible would take whatever steps are necessary. That is our desire.

Senator Moss. Do you have any suggestions on that, Mr. Crawford?

Mr. Crawford. I would have to repeat something that Mr. Hood said earlier. If you took a sample of the bills submitted to public aid, by Northeast or any hospital over any period of time, you could see immediately there are patterns of abuses emerging.

It would be a very simple matter, and apparently, there is little in the way of monitoring these bills that are submitted to public aid. A simple cursory check would show all kinds of areas of abuse.

Senator Moss. Do you think if Illinois had a system more like that of Michigan—that which we heard about this morning—where they could be pointed out on the computer, so that you could then see the spots of possible abuse that this might be cleaned up?

High Recidivism Rate

Mr. Crawford. Absolutely. The recidivism rate at Northeast Community Hospital is phenomenal. I have one example of one individual who entered the hospital. We went back over a 6-month period on these bills. On September 26, 1974, he went into the hospital for 8 days. On October 21, 1974, he was back for 4 days. On January 13, 1975, he was back for another 11 days. He was in 8 more days on April 21, 1975, and back for 9 days beginning May 3, 1975.

This man was in the hospital 47 days over a 6-month period, at a cost to the taxpayer of $3,827.21.

Senator Moss. Well, this obviously is a situation that has to be dealt with, and our concern is, of course, because Federal money is involved. We have an obligation to see to it that money is not wasted or embezzled, or otherwise squandered. We are trying to build our record to see what kind of guidelines there might be with medicare and medicaid.

I certainly commend you both, and I commend the Tribune for having attacked for us a thing of this sort, where you can get right in, and get firsthand knowledge of what is there, and we do appreciate your coming.

Senator Percy has some questions of you.

Senator Percy. Thank you, Mr. Chairman.

I would like to begin with Mr. Gaines first, just to nail down a few particulars. You were first hired as a janitor at Von Solbrig Hospital. Who was it that hired you, and how long did you work there?

Mr. Gaines. Dr. Von Solbrig himself hired me, and I worked more than 2 months.

Senator Percy. How many others were on the maintenance staff?

Mr. Gaines. There were no more than five fulltime employees, including myself. There was one shift of maintenance workers on the day shift. There were no maintenance workers at night or overnight.

Senator Percy. Did the other people on the maintenance staff have the same kind of experiences that you did, or were you an exception rather than the rule?

JANITORS HELP WITH PATIENTS

Mr. Gaines. I saw other janitors being called to assist with the patients. Sometimes they took two janitors to lift a patient, that we were called together to help with the patients.

Senator Percy. Did anyone check your references before you were hired?

Mr. Gaines. No, they did not.

Senator Percy. Would that be normal procedure in the hiring process?

Mr. Gaines. I would hope not. My references were——

Senator Percy. I mean would checking references be a normal procedure, would not the Chicago Tribune check your references?

Mr. Gaines. Yes, I believe so.

The previous employer I put down when I applied was nonexistent, and also I found later that none of my references were called.

Senator Percy. Do you think, despite your lack of professional background, you could have been hired as easily as an aide or as an orderly, than as a janitor?

Mr. Gaines. I did not know it then, but now I realize I could, because I saw a 16-year-old high school student volunteer, put to work as an aide, and also do work in the surgery room without any experience, I am sure I could have applied for that same position.

Senator Percy. I would like to recall for the record the fact that Bill Recktenwald was hired as an orderly in a similar investigation in 1971, and he had similar qualifications as you did for that kind of work.

Were the aides and orderlies, to your knowledge, given any preservice or inservice training?

Mr. Gaines. I never saw any type of training of aides, and I was told by other aides that they had none. I was told by one aide who had been there for 5 years, she came off the street and was put to work.

Senator Percy. In the period you worked at Von Solbrig, did you see any evidence of monitoring of conditions at the facility by State officials?

Mr. Gaines. I was not there at any time when an inspection was conducted, but I learned that since I left, that there was an inspection.

Senator Percy. But while you were there, you saw no evidence of inspection procedures?

Mr. Gaines. No, I did not.

Senator Percy. Would it be apparent to an inspector walking in that there were flagrant violations of minimum standards that should be corrected?

Mr. Gaines. I think by a head count of the nurses and the aides, checking what positions they were assigned to, and the inspector could walk in at any time, and interview these people, and check their qualifications, as they worked, and find this out, but it would not be a matter of just coming in and seeing them, I would not think, because it did take me quite a while myself to find out who was doing what, because in this particular hospital, no one wore name tags, and there was no uniform to designate who had what job.

Conditions Persist Despite Disclosures

Senator Percy. Finally, do you have any reason to, or did you come to any conclusion as to why these conditions could exist, when we had investigations 4 years ago revealing the laxity in inspections by city and State officials? Why is it that a facility like this had to be discovered by you when there are inspectors paid for by departments funded for that very purpose?

Mr. Gaines. I think they did not have enough experience to find out what happens. They have certain lists, and those are the things they would check.

Senator Percy. Thank you very much.

Mr. Crawford, you were admitted into the detoxification program. Could you tell us how you obtained your medicaid card?

Mr. Crawford. Senator, I went through normal channels.

Senator Percy. Could you describe how you dressed yourself, when you went in and applied?

Mr. Crawford. I have a photograph here.

Senator Percy. This is the same one that appeared in the *Tribune?*

Mr. Crawford. Yes, and I was dressed like this to make my case convincing. When applying for the green card, I grew a beard, and I put on some rather raggedly clothes, and took a couple of sips of alcohol before going into the public aid office.

Senator Percy. Do you think that others could do the same thing regardless of their income, and there is no real check on this?

Mr. Crawford. I was amazed at the ease with which I was able to get the card. There were certain bureaucratic headaches. I was called back a couple of times for appointments, for further processing of my application, and got there only to find the time had been set up wrong; or my intake worker was not available, and I would have to come back the following day.

Woe to the man who really needs this type of care.

Senator Percy. This is not an invesigation of welfare as such, but it would certainly seem right on the face of it that if we were to eliminate fraud in the program, the place to begin is right at the beginning, before someone goes on the rolls. In the case of need, they have to put you on immediately, but there ought to be some followup to investigate thoroughly your need. How much could your cost run a year, just for you, as a single man on aid, how much would that cost the Government, so long as you stayed on this, without really needing it, but getting a card under the circumstances you did?

Mr. Crawford. Including the cost of medical care?

Senator Percy. Yes.

Mr. Crawford. It could have cost as much as $10,000.

Senator Percy. A year?

Mr. Crawford. Yes.

Senator Percy. So a little investigation, a little casework would really pay?

Mr. Crawford. Absolutely.

Senator Percy. And do you have reason to believe that this one of the problems with the public aid program?

Mr. Crawford. Yes, I do.

Patient Spent 47 Days in the Hospital

As I explained to Senator Moss earlier, I have the case of an individual who had been in the hospital 47 days in a 6-month period, and it cost $3,628. It seems to me, if you were screening these people, and these bills that were submitted to IDPA, this is one case that would have popped up immediately. This case would have been kicked out of a computer.

Senator Percy. How many other patients were in the detoxification unit while you were there?

Mr. Crawford. The hospital is a general hospital. It has 100 beds, but the overwhelming majority of the patients are there for detoxification. I guess perhaps 70 to 100 patients were in there for detoxification.

Senator Percy. How many of the patients were medicaid eligible?

Mr. Crawford. About 90 percent.

Senator Percy. Did you see any evidence of monitoring of conditions by the State or local officials while you were a patient?

Mr. Crawford. No, sir.

Senator Percy. Why would anyone want to go to a hospital, which the *Chicago Tribune* has described as hot, filthy, and infested with cockroaches?

Mr. Crawford. I don't know. It is a very complicated sociological question. The type of person you are dealing with tends to be dependent. If he has an alcoholic problem, he tends to depend on people, and many of these people wind up spending their monthly check in a very short period of time, and perhaps there is just nothing else available to them.

Senator Percy. Could anything really fundamental have happened to an individual going through the detoxification unit and the treatment?

Mr. Crawford. Pardon me?

Senator Percy. Could anything have changed, could a person have been rehabilitated if submitted to the kind of detoxification treatment you received?

Mr. Crawford. Out of the question.

Senator Percy. Mr. Chairman, I should like to ask unanimous consent for insertion into the record at this point the series of articles* that were done by the Chicago Tribune Task Force.

Senator Moss. Without objection, the articles will be printed in the record, and we are very glad to have them.

Senator Percy. I think that they would be helpful. The testimony has been boiled down. The experience both of you have had has been very concisely put in your testimony, and we appreciate that. But there are so many basic things that are brought out in this entire series, as in series from other newspapers, one by the *Chicago Daily News*, the *Sun Times*, for instance. One of the articles deals with the staff at the hospital.

There is a picture, and I am sorry that we cannot put pictures in the record but there is a picture of the staff directory in the lobby of the Von Solbrig Hospital. Very imposing, staff doctors, and names of them, how many names roughly are on that list?

Fifty Names on Hospital Roster

Mr. Gaines. There are 50 names on that list.

Senator Percy. And how many of them actually could be located by you, that actually worked at the hospital?

Mr. Gaines. Eighteen persons. They were not staff doctors, but at one time, they had a patient there, and considered themselves associated in some way at the hospital.

Senator Percy. Were all of the doctors listed on that list alive?

Mr. Gaines. No. Several were dead. Some had never brought a patient to the hospital.

Senator Percy. Do you suppose they were still voting in Cook County? I will not ask for an answer to that.

So that there was an apparent deception here, or at least the listing had fallen out of date certainly. I thought it was rather interesting that Dr. Oldberg, one of our most distinguished doctors and public officials in Chicago, president of the Chicago Board of Health, indicated that a review should be made by the utilization review committee of the hospital. The group is responsible for monitoring the level of patient care at the hospital. What was the nature of that review committee? It sounded great, but how frequently did it meet?

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*See appendix 2, p. 110.

Mr. Gaines. It was supposed to meet at least once a month, but I believe there was testimony it met once every 2 months, and it was supposed to have board-certified physicians, and instead it had a doctor that was not board certified, it had the wife of the owner of the hospital, and it had a nurse at the hospital, who was employed directly by the doctor.

Senator Percy. Doctor Oldberg, when he had heard about this situation, said that is the most reprehensible thing we have seen in print about this hospital.

In fact, the article said that that is absolutely unacceptable to the Chicago Board of Health. You are on definite probation for 1 month. I wonder what your judgment is when Dr. Oldberg, and he may be limited by what he can actually do, puts Dr. Solbrig on probation? I wonder if that really shakes up other such institutions that may be operating with some of these same conditions.

It said he did not have to empty the hospital, but in that time, 1 month, he has got to get board-certified specialists on the committee.

Now, that just seems to be a knuckle rapping that would be somewhat inconsistent with the nature of I think the "crime" against society, and I put crime in quotes, because I do not know what law, if any, the doctor may have broken here. But it seems to be a rather light penalty, taking into account the circumstances that have beeen revealed.

Ongoing Investigation

Mr. Gaines. That 1-month period has not expired, and we are told the Board of Health is now conducting a further investigation, and at that time, there will be hearings, and more questions will have to be answered by the hospital, but at that time, we do not know if that will be the extent of this action.

It seems to me when Dr. Oldberg said that what we were showing is what the result is of not having that board, and the type of condition resulting by not having that board.

Senator Percy. Mr. Chairman, I would request that when our hearings are available and printed, in printed form, that copies be sent to appropriate law enforcement officials, the attorney general of the State of Illinois, the State's attorney in Cook County, and other officials, wherever, in whatever county we might have had testimony about.

There are some very serious charges and allegations made here. I think it is up to us to see, as we did in New York, that there will be a followup.

There is no way to stop these practices, other than to punish the offenders, to the fullest extent of the law. I have not looked into the details here, but certainly if laws have been broken, if regulations have been disobeyed, or if fraud in any way has been committed at some point, then we ought to take a pretty careful look at it.

Senator Moss. Well, gentlemen, we do thank you very much for your excellent testimony.

Mr. GAINES. Thank you.

Senator MOSS. Our last witness of the day is Edmond L. Morgan, past president, the American Association of Bioanalysis; executive secretary, Illinois Association of Clinical Laboratories, Park Ridge, Ill.

We appreciate your coming. We know it has been a long wait, sir, and we are sorry to detain you for this long wait, but we are anxious to hear your testimony.

STATEMENT OF EDMOND L. MORGAN, PAST PRESIDENT, AMERICAN ASSOCIATION OF BIOANALYSIS; EXECUTIVE SECRETARY, ILLINOIS ASSOCIATION OF CLINICAL LABORATORIES, PARK RIDGE, ILL.

Mr. MORGAN. Thank you, Mr. Chairman. Probably the reason I am requested to appear, I have worked closely with George Bliss of the Better Government Association in supplying leads to many of the cases we have found, particularly the Von Solbrig Hospital, and then there are other cases.

Our members are distressed about the overall problem of unethical business practices in the laboratory, where we began our investigation about 5 years ago.

Members were complaining, they were refusing to pay dues because there were certain facilities operating unethically, and you wonder how they acquired their license under medicare certification, in which they were not fully complying with the law.

One member complained of kickbacks, and we had particularly complaints of four laboratories, so we ventured into these four laboratories and confronted most of these people. But there was only one real way to find out where the abuse was, and that was through bills, if possible.

We discovered what we suspected, that these laboratories were involved in heavy overutilization, that they were padding bills and using factoring agencies.

The amounts paid to these laboratories were substantial in relation to what they were making. We are also amazed that the system in Illinois was not able to catch this heavy overutilization.

There was very little we could do about it. We complained about overutilization, which appeared to be a problem for the medical society, and not only for our area, and since we are mostly not physicians, we are chemists and bioanalysts.

When the investigation started with Mr. Bliss, I called and asked him if he could check out this problem of overutilization, and he went down to Springfield with me, as I mentioned, we did go to the department of public aid, we showed them what we suspected, and pointed out the evidence, and there was very little they could do.

POLITICAL "CLOUT" HAMSTRINGS DEPARTMENT

Apparently the people in the public aid department are very good people, but there are political pressures, and we were told it would require some clout.

We decided to investigate this clout. Apparently the clout came to the point in which many years ago, approximately 3 years ago, members were complaining, that it was no longer 2 and 4 months payments, it was now becoming 6, 8, 12 months, and in many instances, 1½ years.

The worse we could make of the situation was that it was one of these problems that we do not know how to solve.

We did propose a bonding system in Illinois through the legislative advisory commission. The bonding system was proposed to the department of public aid, and when Joe Abelman was director of public aid, he presented this to the commission, they accepted it, and he announced it in a press conference that Illinois would no longer accept the factoring companies, that they had totally switched to the bonding system.

This required maintaining a percentage of the bills. We suggested 85–15. The commission suggested 80–20, which was acceptable.

The bills would be reviewed after payment, and probably 5 percent of the bills would be reviewed.

We requested several safeguards, one was a maximum payout limit on any particular month, which was acceptable. The other was a professional review committee, which would replace the present medical advisory boards in many of these public aid agencies, and we found the physicians on the medical advisory boards were not responsive themselves.

We felt younger professional people, not just physicians, should be on these medical advisory boards. I will go on to some of the problems we have seen.

We also discovered that the overutilization of laboratory services in areas which we call green card areas, did not surfaced in other areas, such as a community like Park Ridge, where the community is wealthy enough to afford a lot of laboratory work, this does not happen.

The average bills we found in Springfield were near $75 a patient. I have other bills which I was not able to copy and attach.

This was not occurring in all areas in Illinois. It only happens to appear when we saw bills on the green card. It also happens in nursing homes. I was discussing bills and overutilization of laboratories.

In discussion with members at reimbursement hearings, it was drawn out that there was only one reason for this heavy overutilization, heavy padding of bills, and this involved a kickback system.

Compensation was given physicians in the form of moneys, and other gifts such as free employees in clinics, et cetera, free autos, paid personal bills, and business bills.

MAJORITY OF LABS USED FACTORING AGENCIES

We noted too, that the majority of these laboratories that were submitting these bills went through factoring agencies to facilitate payment.

Last year in 1974 my office began working with the Legislative Advisory Commission to the Department of Public Aid.

Two policemen were assigned to my office to investigate these complaints. We walked into six different laboratories. We had copies of bills we secured in Springfield, and we demanded to see verification records of these in the laboratory.

Only one laboratory produced any substantial records that they actually did the testing.

Now, I think I have a list* of those here. Most of the laboratories in Illinois do accept medicare payments. Most of the nursing homes in which we must journey to draw our specimens from the patients. In 1967 we formed a model nursing home contract. At that time there was quite a bit of kickback in the nursing home industry. We insisted the members use the contract.

Although there were some flaws in the first initial contract, it has been cleaned up, and today medicare requires a contract be definitely demonstrated between a medical laboratory and a nursing home, and it is supposed to be in their file.

It eliminates the kickbacks, although there is still some of it going on in Illinois with laboratories who are not members.

It has also been our experience that medicare recipients do not receive the same consideration as the regular public aid.

Medicare will pay 80 percent, and public aid of the State of Illinois, for the medicaid patient, pays 20 percent. Usually the department of public aid will indicate you have already been paid more that normally allowed by medicare, and this attitude of the department of public aid we attribute to the problem of the factoring system.

The factoring agencies have not succeeded in reaching medicare to the extent they have public aid. It has come to our attention that certain criminal elements are involved in the purchase of laboratory bills.

I think the rest of the points I do not need to go into since they are in my prepared statement.*

Senator Moss. Thank you. Senator Percy, I believe you have some questions.

Senator Percy. Thank you, Mr. Chairman.

Mr. Morgan, did you bring your findings to the attention of the Governor's medicaid task force, or the Illinois Department of Public Aid director?

Mr. Morgan. We were told that there is very little that could be done. Most of this involved overutilization. We had not proved fraud yet, and then I began working with the department of public aid.

Rebuffed for 5 Years

Senator Percy. Were you rebuffed in any way in your attempts to correct the abuses of the medical laboratories?

Mr. Morgan. For 5 years we have been.

Senator Percy. Was there no one in the Illinois Department of Public Aid or the Governor's office interested in stopping the misuse of public moneys, $100 million to $125 million out of $600 million spent annually in Illinois for public aid health care as you point out on page 4?

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*See statement and attachments, appendix 3, p. 129.

Mr. MORGAN. Was the Governor's office interested?

Senator PERCY. Yes.

Mr. MORGAN. My personal opinion is no.

Senator PERCY. How about HEW, did you also contact any Federal official?

Mr. MORGAN. I contacted the regional representative, Mr. Green, and we were given the fullest cooperation, and they will not pay the factoring people.

Senator PERCY. How did you arrive at your estimate that 1 in 6 medicaid dollars is siphoned off through fraud or illegal billing?

Mr. MORGAN. These facts are supplied by the investigators.

Senator PERCY. Finally, what changes in the Federal regulations do you suggest to rid the program of the abuses you described?

Mr. MORGAN. We have heard so much about abuse and overutilization, it also occurs in our own industry.

We proposed language very similar to that which would require payment within 30 days. This would eliminate the factoring. It was announced, and the factoring agencies sued the department of public aid to avoid it, a system of bonding. It was a fairly good mechanism, with some built-in checks and devices.

Today the bonding system is still not introduced in Illinois.

Another solution I proposed was perhaps the professional review committee, not just physicians, because the medical advisory committee in public aid has strictly physicians.

We have attempted to get members on this committee for years with no success. I understand with the professional standards review organizations, it will be required that other professionals besides physicians be on these managing committees. It will take time to set these mechanisms up.

Another one is legislation which would prohibit the factoring agencies for medicaid bills, and we would also like to see legislation that would prohibit ownership of professional services like laboratories and pharmacies by people not professionally connected or not professionally responsible.

Senator PERCY. I overlooked asking you one question, because I had not read your testimony. At the time you got into this and saw the pattern developing in Illinois of slowness in paying medicaid bills you concluded that it might not just be due to inefficiency, but it might be perhaps tied in with political clout. By that, are you inferring and arguing that the factoring companies actually add to the cost of the Illinois Department of Public Aid?

Would you want to amplify on that, and if you have any specific names of companies, individuals, and politicians that you would like to mention, that you think we ought to question or investigate further, that we could learn something from, I would appreciate your being quite specific on that.

Mr. MORGAN. The department of public aid has a member who resides on our Laboratory Reimbursement Committee.

No Authority To Act

Unfortunately, the committee has no authority; however, it does have four members of the carriers, we have four members, and there are four members who are specialists, they are not necessarily members.

The department of public aid has been on this committee with us now for 4½ years, almost 5.

We have worked out situations with them before on reimbursement schedules, payment for blood drawing fees at nursing homes, which has incurred extra travel costs, but we hit a stumbling block 3 years ago, when the new administration came in, and apparently there was a slowness in payments at that time, but it is not what it is today.

Senator Percy. I want to thank you very much indeed.

Senator Moss. We certainly do appreciate your appearance.

I was concerned about your allegation that there must be clout in Springfield to get proper reimbursement, and that this requirement of clout is attributed to the interference of so-called factoring agencies into the internal affairs of the Department of Public Aid.

That is what you and Senator Percy were talking about?

Mr. Morgan. That is what I understand, that this is true.

Senator Moss. I am also struck by your association's estimates that approximately $10 to $12 million annually has been siphoned out of health care dollars in Illinois through the passing of laboratory bills and overutilization.

Mr. Morgan. That is correct. These figures are estimated by the investigators to the commission.

Senator Moss. Well, thank you very much. I appreciate your coming and testifying and pointing out these problems to us. Your prepared statement in full will be made a part of the record.*

I do thank all of the witnesses. It has been a long session, but a most productive one, and we do appreciate very much the cooperation we have received.

We now stand adjourned.

[Whereupon, the hearing was adjourned at 1:45 p.m.]

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*See appendix 3, p. 129.

APPENDIXES

Appendix 1

MEDICAID INVESTIGATION SECTION REPORT; SUBMITTED BY PAUL M. ALLEN,* MICHIGAN DEPARTMENT OF SOCIAL SERVICES

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TAB A

MEDICAID INVESTIGATION

The Michigan Department of Social Services, which is the single State agency administering the medicaid program in the State of Michigan, is, among other things, charged with the responsibility for:

(1) Verifying that claims submitted to the program by providers of services are valid claims.

(2) Establishing criteria and methods for determining where there is valid reason to suspect that fraud or abuse against the program has been committed.

(3) Investigation of suspected or alleged cases of fraud.

(4) Recovery of moneys paid in cases of fraud or abuse.

(5) Referral to law enforcement officials (county prosecutors and local police agencies of cases of fraud to secure prosecution.

(6) Liaison, working arrangements, and referral to other related State and Federal agencies and licensing boards.

To this end, the medicaid investigation section has been established within the program integrity division of the bureau of medical assistance. The current authorized staff of this section is 23 persons (fiscal year 1974–75). Under Federal regulations:

A. Title XIX of the Social Security Act, as amended, section 1902(a)(4)(A).

B. 45 CFR 250.80, March 27, 1971.

C. SRS Program Regulations 40–14 (C–1) dated March 27, 1971.

Situations which could suggest the possible existance of fraud would include:

1. Billings for services, supplies, or equipment which were not rendered to, or used for medicaid patients;

---

*See statement, p. 9.

2. Billings for supplies or equipment which are clearly unsuitable for the patient's needs or are so lacking in quality or sufficience for the purpose as to be virtually worthless;

3. Flagrant and persistent overutilization of medical or paramedical services with little or no regard for results, the patient's ailments, condition, medical needs, or the doctor's orders;

4. Claiming of costs for noncovered or nonchargeable services, supplies, or equipment disguised as covered items;

5. Material misrepresentations of dates and descriptions of services rendered, or of the identity of the recipient or the individual who rendered the services;

6. Duplicate billing which appears to be deliberate. This includes billing the medicaid program twice for the same services;

7. Arrangements by providers with employees; independent contractors, suppliers, and others which appear to be designed primarily to overcharge the medicaid program with various devices (commissions, fee splittings) used to siphon off or conceal illegal payments;

8. Charging to the medicaid program, by subterfuge, costs not incurred or which were attributable to nonprogram activities, other enterprises, or personal expenses.

Investigations are generated by several methods:

(1) Complaints from recipients or providers,

(2) Referrals from other agencies or areas within this department,

(3) Review of computerized records and claims history files of services billed for providers and/or received by recipients.

Investigators in this section currently investigate cases of suspected fraud, perform claims review of providers' billings to the program as well as investigate cases of fraud and program abuse by program recipients. The provider types investigated include all direct-billing providers of medicaid services as well as specially assigned investigations where fraud is suspected or uncovered in institutional provider settings.

Well Qualified Investigators

The investigations performed are highly specialized in each provider type and require specialized expertise by the investigators. During the first full year of operation of this section (fiscal year 1973–74) all of the staff was not employed for the full fiscal year. At the end of the fiscal year, this section had a staff complement of 15 investigators including supervision and 4 clerical staff members. In addition to the fact that all investigators were not employed for the full year, a large portion of their time was involved in intensive in-service training in the investigation of the specialized provider types. Of necessity, the section investigators include expolice officers (investigators), former drug salesmen, pharmacists, medical laboratory technicians, people with public health backgrounds, and investigator trainees with law enforcement degrees.

The following are the areas investigated and usual procedures followed in the various provider types by medicaid investigation section personnel:

A. *Practitioner* (M.D. or D.O.) also chiropractor, podiatrist:

1. The "in-house" review of samplings of physicians' and/or recipients' billings history prior to the actual field claims review to: (a) Establish billing trends, (b) Establish possible areas of abuse or overutilization, (c) Look for double billings for services, etc.

2. Verification that services were received by direct contact with the recipient.

3. Verification of claims by review of medical records at the physician's office. This involves the actual review of medical records, the complaint, diagnosis, history, dispensing record, and treatment record. It also includes the actual review of laboratory results, EKG results, various specialized tests, X-rays, etc.

4. Establishment of usual and customary. This is to establish the normal charges to cash-paying customers and to verify that the medicaid program is not charged above the usual and customary charge by the practitioner.

5. The observation of billing and treatment practices which include "re-calls" or call-backs or recipients in order to generate extra professional fees as well as "nonmedically necessary" treatments or procedures billed for. In this particular area of questionable medical necessity, if and/or when it becomes necessary for peer-review, this area is referred to physician review and is then returned to the section for final analysis and refund calculation, if any.

6. Development of cases of "kick-backs" or collusion between providers if found or indicated.

B. *Pharmacy:*

1. Establishment of usual and customary charges to the public to ascertain that the medicaid program is not billed above the pharmacy's usual charges.

2. The establishment of true acquisition cost of drugs billed the program. The program requires the passing on to the program of all discounts received in excess of 2 percent.

3. Veryfying through pharmacy and computer records the presence, if any, of (a) double billings; (b) "add-on" or fraudulent billings; (c) prescription splitting—the generation of extra prescriptions by only partially filling the original prescription, or in the case of nursing home supplying pharmacies, the generation of prescriptions on less than a 30-day basis, thus generating extra professional fees to the program.

4. Verification of authenticity of prescriptions with physician.

5. Verification of actual drug dispensed in comparison to the drug prescribed (i.e. substitution of lower priced generic equivalent drugs while billings the program for higher-priced trade name drugs).

6. Development of cases of kick-backs or collusion between providers if found or indicated.

C. *Ambulance:*

1. Verification with physicians of the "medical necessity" of all return trips from a hospital or other institutional setting (basically not allowed service).

2. Verification of mileage billed for.

3. Review for double billings.

4. Verification that services were performed.

5. Verification of special services billed for: (a) Oxygen or resuscitation; (b) emergency run; (c) night run.

6. Development of cases of kick-backs or collusion between providers if found or indicated.

D. *Laboratory:*

1. Verification of usual and customary.

2. Establishment of equipment and instrumentation of the laboratory and verification if the program was billed for higher priced individual tests while performed by lower cost automated equipment.

3. Verification of physicians' order for laboratory work—laboratory findings.

4. Verification that services were performed.

5. Development of cases of kick-backs or collusion between providers if found or indicated.

E. *Special Services* (optometrists, opticians, hearing aid dealers, methadone clinics, shoe suppliers, oxygen suppliers, medical supplies providers, etc.): All of the above procedures which relate to these providers.

F. *Dentist:* All of the above procedures which relate to these providers in addition to the special requirements of the dental field.

G. *Hospital and Nursing Home:* All of the above procedures which apply to these providers in addition to special requirements of the investigation.

NOTE.—Investigators from this section "shop" providers posing both as medicaid recipients, with car, or as cash customers as follows:

1. *Pharmacies:*

A. To verify current "usual and customary" charges to the public.

B. If complaint generated, to check for "shorting" on the amount of prescriptions dispensed.

C. If suspected or complaint generated to establish whether or not low cost generic drugs were dispensed and if trade name drugs were billed for.

D. If complaint generated or suspected, to establish if "add-on," nondispensed drugs are added to the medicaid claim.

2. *Practitioners:*

A. Usual and customary.

B. Establish abuses such as routine screening tests.

C. Verify if additional charge are made to medicaid recipients.

D. Tests ordered by physician billed to medicaid but not done.

E. Comprehensiveness of billed procedures per manual description of specific procedure codes.

F. If services billed were rendered by an enrolled and licensed practitioner.

3. *Laboratory* (through cooperating physician):

A. Establishing quality of laboratory results.

B. Improper billing practices.

C. Usual and customary charges.

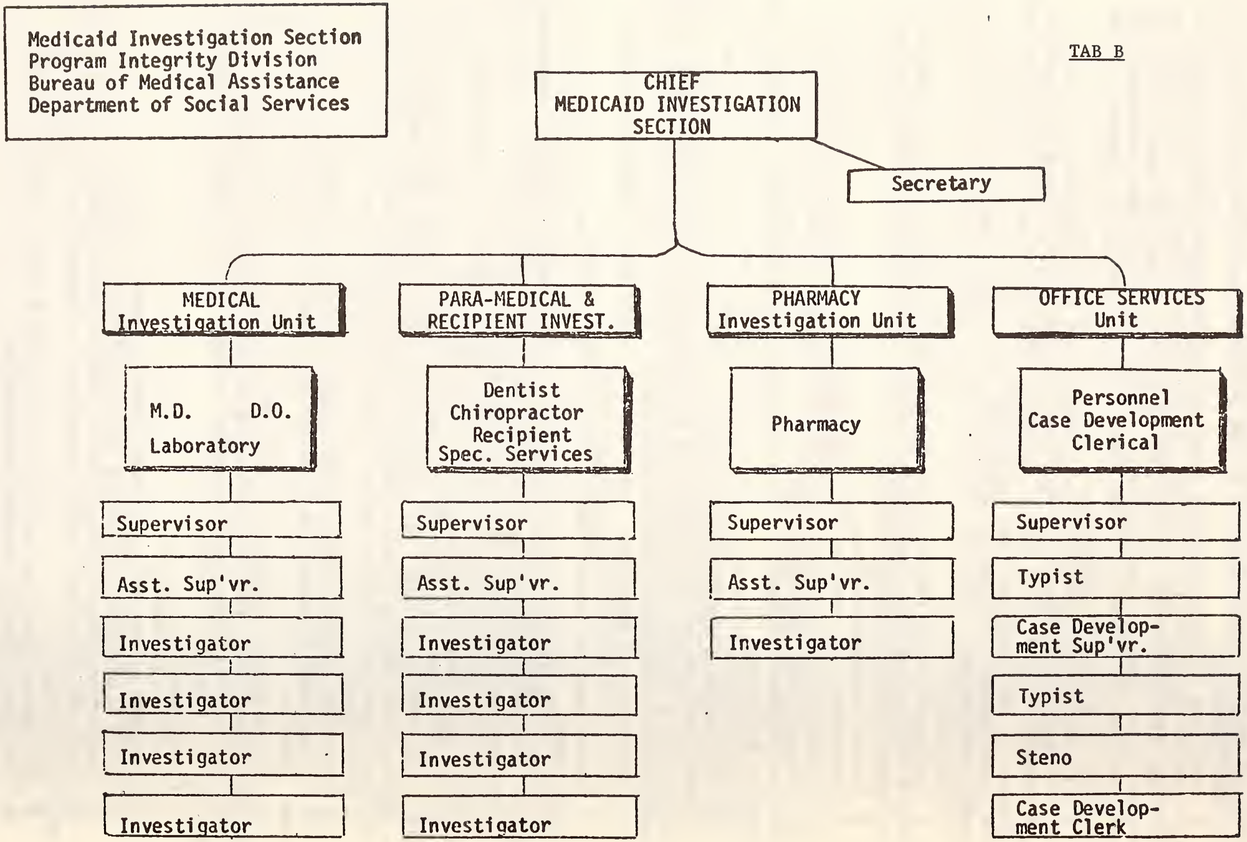
4. *Special Services:*

A. *Optometry:* (1) Additional charges to recipient; (2) quality and completeness of eye examination; (3) Usual and customary charge verification.

B. *Dentist:* (1) Usual and customary; (2) billing for services not prior authorized.

C. *Hearing Aid:* (1) Usual and customary; (2) type and quality of merchandise dispensed.

TAB B


Medicaid Investigation Section
Program Integrity Division
Bureau of Medical Assistance
Department of Social Services
CHIEF
MEDICAID INVESTIGATION
SECTION
Secretary
MEDICAL
Investigation Unit
M.D.
D.O.
Laboratory
Supervisor
Asst. Sup'vr.
Investigator
Investigator
Investigator
Investigator
PARA-MEDICAL &
RECIPIENT INVEST.
Dentist
Chiropractor
Recipient
Spec. Services
Supervisor
Asst. Sup'vr.
Investigator
Investigator
Investigator
Investigator
PHARMACY
Investigation Unit
Pharmacy
Supervisor
Asst. Sup'vr.
Investigator
OFFICE SERVICES
Unit
Personnel
Case Development
Clerical
Supervisor
Typist
Case Development Sup'vr.
Typist
Steno
Case Development Clerk

1973-74 FISCAL YEAR REPORT

CASES CLOSED—FISCAL YEAR 1973-'74

MEDICAID INVESTIGATION SECTION	Agreements Reached					
	NO REFUND	REFUND	TOTAL	% GENERATING REFUNDS	REFUND DOLLARS	PROGRAM SAVINGS (1-YEAR)
PHARMACY	5	43	48	89.58	$ 396,416.24	$ 141,144.05
OSTEOPATH	1	11	12	91.67	237,997.20	199,955.43
M. D.	4	22	26	84.62	169,075.65	109,424.57
LABORATORY	-	5	5	100	50,474.55	59,295.70
RECIPIENT	86	23	109	21.10	32,388.72	69,558.72
AMBULANCE	1	10	11	90.90	8,009.36	2,971.69
CLINIC	3	2	5	40.00	1,643.75	1,956.90
NURSING HOME	-	8	8	100	99,000.00	78,705.88
CHIROPRACTOR	-	1	1	100	70.00	56.00
DENTIST	-	1	1	100	250.00	--
HEARING AID	1	-	1		---	--
	101	126	227		$ 995,370.47	$ 663,068.94

Actual refunds $995,370.47
1 year savings 663,068.94
$1,658,439.41
Divided by Section expenditures 280,000.00 = 5.92 dollars returned for each dollar spent

P S & I SECTION	CASE HOURS	% OF TYPES INVESTIGATED			MAN HOURS EXPENDED BY TYPE			
	Average hours expended on each.	Cases CLOSED and PENDING agreements.			Field Invest.	Travel Time	Case Dev. & Clerical	TOTAL
		Cases	Providers	%				
PHARMACY	88 cases = 67.3 ea.	59	2,000	2.95	4,019.0	774.25	1,132.0	5,925.25
OSTEOPATH	44 " = 40.9	20	1,950	1.03	1,407.5	182.5	210.25	1,800.25
M. D.	68 " = 15.9	26	9,550	.27	829.5	195.5	58.0	1,083.0
LABORATORY	5 " = 2.4	5	107	4.67	6.0	3.0	2.75	11.75
RECIPIENT	154 " = 15.3	(not applicable)			1,509.0	716.0	135.0	2,360.0
AMBULANCE	34 " = 33.4	17	333	5.71	919.0	107.0	109.0	1,135.0
CLINIC	6 " = 47.2	(not applicable)			236.25	43.5	3.25	283.0
NURSING HOME	15 " = 34.5	(not applicable)			422.5	39.5	55.5	517.5
CHIROPRACTOR	3 " = 25.8	1	670	.17	64.25	11.5	1.75	77.5
DENTIST	1 " = .3	1	3,335	.03	--	--	.25	.25
HEARING AID	1 " = 13.0	1	132	.76	9.0	3.0	1.0	13.0
					9,422.0	2,075.75	1,708.75	13,206.5
					Mg'mt. (3-Supv. & 1-Secretary)			6,207.5
					Misc. (In office time)			1,682.0
					Training Time			5,377.25
					TOTAL HOURS			26,473.25

TAB D

1974-75 FISCAL YEAR REPORT

MEDICAID INVESTIGATION SECTION	CASES CLOSED - FISCAL YEAR 1974 - '75						PLUS
	Agreements Reached						
	NO REFUND	REFUND	TOTAL	PERCENTAGE GENERATING REFUNDS	REFUND DOLLARS	AVERAGE REFUND GENERATED PER CASE	PROGRAM SAVINGS (1-YEAR)
M.D.	11	13	24	54%	$ 69,643.46	$ 5,357.19	$ 31,698.99
Osteopath	4	29	33	88%	665,864.85	22,960.86	304,147.93
Dentist	1	3	4	75%	1,586.00	528.67	7,491.00
Ambulance	1	16	17	94%	32,507.52	2,031.72	14,080.72
Pharmacy	2	28	30	93%	167,156.23	5,969.87	62,085.76
Optometrist	1	2	3	67%	50,150.00	25,075.00	29,146.84
Recipient	77	45	122	37%	105,742.16	2,349.83	112,384.61
Case Subtotals:	97	136	233	58%	$1,092,650.22	$ 8,034.19	$561,035.85
Special Refund Recovery Projects Subtotals	--	138	138	---	$ 107,903.84	$ 781.91	----
TOTALS:	97	274	371		$1,200,554.06	$ 4,381.58	$561,035.85

Actual refunds	$1,200,554.06		
1 year savings	561,035.85		
	$1,761,589.91		
Divided by Section expenditures	380,000.00	=	4.64 dollars returned for each dollar spent

MEDICAID INVESTIGATION SECTION	CASE HOURS	MAN HOURS EXPENDED BY TYPE				% OF TYPES INVESTIGATED		
	Average hours expended on each	Field Invest.	Travel Time	Case Dev. & Clerical	TOTAL	Cases CLOSED		
						Cases	Enrolled Providers	%
PHARMACY	82 cases = 41.7 ea.	2,009.5	359.5	1,050.75	3,419.75	30	1,877	1.6
M.D.	91 cases = 160.7 ea.	5,940.0	623.25	347.0	6,910.25	24	10.550	.23
D.O.	78 cases = 113.3 ea.	7,980.75	1065.0	572.25	9,618.00	33	1,911	1.7
AMBULANCE	34 cases = 23.5 ea.	404.75	115.5	279.5	799.75	17	295	5.8
RECIPIENT	160 cases = 7.1 ea.	772.0	279.5	84.75	1,136.25	--	Not Applicable	--
DENTIST	21 cases = 19.0 ea.	128.0	216.75	54.0	398.75	4	3,194	.13
OPTOMETRIST	10 cases = 41.7 ea.	288.5	66.0	62.25	416.75	3	856	.35
CHIROPRACTOR	3 cases = 69.3 ea.	126.0	66.5	15.25	207.75	--	650	--
LABORATORY	5 cases = 9.8 ea.	35.0	14.0	--	49.0	--	100	--
PODIATRIST	2 cases = 10.3 ea.	10.5	8.0	2.0	20.5	--	285	--
MED. SUPPLIER	1 case = 1.0 ea.	1.0	--	--	1.0	--	350	--
UNLICENSED PROVIDERS	10 cases = 20.9 ea.	125.5	56.0	27.75	209.25	--	Not applicable	--
		17,821.5	2870.0	2,495.5	22,187.0			
		Mg'mt. (Chief, 4 Supervisors, 1 Secretary)			10,296.00			
		Miscellaneous (In-Office Time)			1,027.50			
		Training Time			1,460.25			
		TOTAL HOURS			34,970.75			

TAB E

Pharmacy: Summary Investigation Report

(Case No. 41–72–2)

CASE BACKGROUND

A. *Reason for case initiations.*—This claims review was performed on the basis of a report forwarded to this unit from the Invoice Processing Division regarding possible overcharges to the medicaid program.

B. *Previous claims review record.*—A previous claims review was performed on this pharmacy provider on February 18, 1971, by Michigan Blue Shield. At this time, six prescriptions were checked and found to be in good order. No problems noted.

C. *Claims review period and volumes:*

1. Claims review period March 1, 1971 through December 31, 1973.
2. Volume of payment during above time period $882,217.78.

D. *Claims review.*—The claims review was conducted on January 15, and January 17, 1974. Over 1,500 claims were reviewed.

CLAIMS REVIEW FINDINGS

A. Inaccurate acquisition cost reporting and billing for a brand name drug when a generic drug was actually dispensed to the recipient.

B. Billing for noncovered items (for recipients residing in a long-term care facility).

C. Prescription splitting.

ACTION TAKEN

A. Further payment of claims were suspended.

B. On February 12, 1974, Bureau personnel met with pharmacy personnel. At this meeting, the pharmacy stated that only 2 of the 28 nursing homes serviced by them were being supplied with generics. Before this meeting closed, the number of homes being supplied with generics increased to four. In the original investigation report the percentage of generics calculated to have been used in all 28 homes was 36.21 percent. On January 15, 1974, the owner stated to investigators that he used 60 percent generics. On January 17, 1974, he stated he used 50 percent generics. On these dates, investigator were supplied with only a small number of invoices showing generic purchases.

C. In later conferences, the owner stated that only five generic drugs were used in four nursing homes.

D. Investigation developed a confidential informant who advised that this pharmacy was substituting generic drugs for brand name drugs and was billing the program for brand name drugs. Further, that on one visit to the pharmacy generic drugs were hidden in trucks while investigators were in the pharmacy.

E. On March 7 and 8, 1974, investigators entered 25 of the 28 nursing homes serviced by this pharmacy and obtained samples of 31 different generic drugs supplied to these homes. In comparing the prescription numbers for these generics with the billings submitted by this pharmacy, it was discovered that the program was billed for the brand name drugs.

F. Investigators returned to the pharmacy and reviewed all invoices supplied to them in an effort to determine the percentage of generics purchased. Only 7.63 percent of all drugs purchased were generic with the invoices supplied.

G. Further requests were made of the pharmacy to supply generic acquisition invoices and finally they agreed to show investigators check stubs for payment to various companies. It was revealed that they had purchased drugs from 39 sources of supply not revealed to investigators previously; many of these being generic drug manufacturers.

FURTHER ACTION TAKEN

A. A statement of findings was compiled by investigators.

The violations are as follows:

1. Billed the medicaid program for noncovered items for recipients residing in long-term care facilities.
2. Reported inaccurate acquisition cost.
3. "Split" prescriptions to generate extra professional fee.
4. Repeatedly failed to supply drug purchase records.

5. Gave untrue statements to BuMA investigators regarding generic drugs dispensed by them.

6. Dispensed generic drugs to medicaid recipients and billed the program for higher priced brand name drugs.

7. Submitted improper questionable billings to the program (service not performed by a pharmacist).

B. The pharmacy was given notice of termination from the program, and BuMA personnel met and negotiated a refund of $120,000, based on input from the pharmacy.

RESULTS

A. The pharmacy was suspended from the program and did pay the total of $120,000 refund.

B. Case closed.

TAB F

Pharmacy Summary Investigation Report

(Case No. 1–73–1)

CASE BACKGROUND

A. *Reason for case initiation.*—This claims review was initiated as a result of a recipient complaint stating that shortages and possible program abuse existed with this provider.

B. *Previous claims review records.*—Several claims reviews were conducted on this pharmacy from 1967 through 1972 by Michigan Blue Shield, with no refunds requested, even though many discrepancies were noted.

C. *Claims review period and Volumes:*

1. Claims review period January 1, 1967 through August 23, 1973.

2. Volume of payment during above time period $131,676.84.

3. Claims review conducted in July, August, and September of 1973.

CLAIMS REVIEW FINDINGS

A. Inaccurate acquisition cost reporting.

B. Provider was purchasing large amounts of generics not reflected on his invoices.

ACTION TAKEN

A. Provider was "shopped" by an investigator posing as a medicaid recipient with a valid medicaid card. This provider billed the program for brand name drugs in larger quantities than actually dispensed. The medications dispensed were generics. The provider billed the program for a larger quantity of a brand name drug and dispensed a smaller quantity of a generic on several occasions when shopped by medicaid investigators posing as medicaid recipients.

B. Further investigation involved the following: Reviewing invoices, interviewing recipients, interviewing doctors, taking statements, etc.

C. Further findings:

1. The pharmacy was billing the program for medications never received by recipients. *Example:* In a 45-day period of time, the pharmacy billed the program for 18 prescriptions for one recipient which were never prescribed by a doctor or received by the recipient.

2. The pharmacy was billing the program for brand name drugs and dispensing generics.

3. The pharmacy was shorting prescriptions to recipients. *Example:* Billing the program for 100 tablets or capsules and dispensing 60.

4. Unauthorized refills.

FURTHER ACTION TAKEN

A. Payments to the pharmacy were suspended.

B. Meetings were conducted with the pharmacy provider, his attorney, and investigators.

RESULTS

A. This pharmacy repaid $24,692.28 to the program.

B. This pharmacy is reviewed on a regular basis for possible program abuse.

TAB G

Clinic (11 Physicians) Summary Investigation Report

(Case No. 21–734)

CASE BACKGROUND (FISCAL—PART 'A')

A. *Reason for case initiation.*—This claims review was performed on the basis of the high dollar volume of 1 of the 11 doctors operating this clinic, and the abnormally high number of laboratory services performed per recipient.

B. *Previous claims review record.*—No previous review was performed on this clinic by Michigan Blue Shield.

C. *Claims review period and volumes:*

1. Claims Review period January 1, 1972 through December 31, 1973.
2. Volume of payment during the above time period $1,671,520.69.

D. *Claims review.*—The claims review was conducted in September, October, November 1973.

CLAIMS REVIEW FINDINGS

A. Double billings to the medicaid program.

B. Electrocardiograms with no interpretation or report.

C. Miscellaneous areas (charging the medical assistance program more than usual and customary for laboratory services, etc.).

D. Office calls and injections (charging the medical assistance program more than usual and customary).

ACTION TAKEN

A. In September 1973, approximately 90 medicaid recipients were interviewed to determine the validity of the paid office visits.

B. State medicaid investigators obtained fee schedules for cash customers and Blue Cross recipients and compared these to paid medicaid services.

C. Investigators obtained copies of billings to cash customers (names blanked out) and compared these to paid medicaid services.

D. Investigators posing as cash patients "shopped" the clinics to determine usual and customary charges.

E. In February 1974, a settlement was agreed upon and the clinic agreed to refund $125,000 to the medicaid program for these overcharges.

RESULTS

A. The clinic has refunded $125,000 to the medicaid program.

B. Case closed (fiscal).

C. See attached results of part 'B' of investigation (medicaid).

Clinic (11 Physicians) Summary Investigation Report

(Case No. 21–734)

CASE BACKGROUND (MEDICAL—PART 'B')

A. *Reason for case initiation.*—This area of investigation was performed as a result of the findings of a routine claims review performed by this section. Questions were raised regarding the medical necessity of the abnormally large amount of laboratory tests per recipient.

B. *Previous claims review record.*—No previous review was conducted by Michigan Blue Shield.

C. *Claims review period and volumes:*

1. Claims review period, January 1, 1972 through August 1, 1974.
2. Volume of payment during above time period, $3,376,799.07

D. *Claims Review.*—The claims review consisted of 210 initial claims.

CLAIMS REVIEW FINDINGS (MEDICAL)

A. Questionable areas were noted by investigators, referred to medical review for verification and determination. Findings are as follows:

Procedure

1. *Office visits.*—Clinic was billing for comprehensive office visits while documentation showed a lower paying level of service actually performed.

2. *Lab T–7.*—Nonmedically necessary—blanket order lab tests. This clinic was routinely ordering 14 laboratory tests for each medicaid recipient no matter what the complaint or diagnosis and without relationship thereto.

3. *Chest–X-ray.*—Investigation showed the medical necessity for X-rays billed and paid for was not documented by patient records.

4. *EKG's*—Nonmedically necessary. Investigation showed the medical necessity for EKG's billed and paid for was not documented by patient records.

5. *Pulmonary function.*—Nonmedically necessary. Investigation showed the medical necessity for pulmonary function tests billed and paid for was not documented by patient records.

6. *Culture and Sensitivity.*—Nonmedically necessary—microbiology. No indication in patients' records that these tests were medically necessary and related to the patient's complaint or diagnosis.

7. *Culture.*—Nonmedically necessary—microbiology. No indication in patients' records that these tests were medically necessary and related to the patient's complaint or diagnosis.

8. *Urinalysis.*—Nonmedically necessary and not documented in patient records. No indication in patient's records that these tests were medically necessary and related to the patient's complaint or diagnosis.

DISPOSITION

The final refund figure over $865,000 was requested for the "medical" portion of this investigation. To date, the final refund figure has not been agreed upon by both parties; however, the clinic has to date refunded $337,500.

CASE STATUS

Case remains open.

TAB H

Clinic (Physicians) Summary Investigation Report

(Case No. 356–734)

CASE BACKGROUND

A. *Reason for case initiation.*—This claims review was performed on the basis of an uncommonly high annual volume.

B. *Previous claims review record.*—No record was available relative to a previous claims review performed on this provider by Michigan Blue Shield. Therefore, this provider's claims review period went back to fiscal year 1968.

C. *Claims review period and volumes:*

1. Claims review period January 1, 1968 through December 26, 1974.
2. Volume of payment during above $485,598.59.

D. *Claims review.*—The claims review was conducted on June 23, 31, and August 8, 1974.

CLAIMS REVIEW FINDINGS

A. Provider under discussion is sole stockholder and single officer of a Medical Service Corporation which operated out of 20 clinic locations in a large metropolitan area in southeastern Michigan.

B. The clinic operations employed approximately 80 full and part time physicians and generated roughly $5 million of medicaid billings and payments in 1973–74 fiscal year.

C. The provider under discussion employs licensed physicians in his corporation on a contractual basis for a percentage of generated billings. The individual physicians received approximately 30 to 40 percent of all billings they were able to generate. The provider's corporation received 60 to 70 percent remuneration for such services as office space, equipment, supplies, and so forth.

D. Seven out of the twenty locations were subsequently "shopped" by investigators posing as medicaid recipients on March 3, 1975. At that time unlicensed physicians assistants and medical assistants posed as licensed physicians, diagnosed, treated, and in several cases, prescribed medications to the forementioned investigators. These unlicensed persons were subsequently arrested on complaints by State medicaid investigators for practicing medicine without a license.

E. Use of physician's assistance and medical assistants as licensed physicians.

F. Lack of documentation for the following services:

1. Laboratory work.
2. Office examinations.
3. X-rays.
4. Comprehensiveness of office examinations.
5. EKG's—no interpretations or reports.
6. Injections.
7. Surgery.

G. Billing for services under a provider's identification number whom was not under the employment of the corporation.

H. Billing for services which, according to recipient verification statements, were not rendered.

ACTION TAKEN

A Further payment of claims were suspended.

B. On February 14, 1975, Bureau personnel met with the provider under discussion and his personnel. At this meeting the provider was advised of the findings cited above with the exception of item No. II B.

FURTHER ACTION TAKEN

A. *A statement of findings* was compiled by investigators. The violations are as follows:

1. Billed under provider's I.D. number of physician who had terminated his employment with corporation 3 months prior to service dates.
2. Utilized physician's assistants and medical assistants as clinic physicians.
3. Repeatedly failed to produce documentation of services.
4. Gave untrue statements to Bureau of Medical Assistance investigators regarding billing policies and services rendered.
5. Submitted improper or questionable billings to the program (service not performed by licensed physicians).

B. The provider and corporation was given notice of termination from the program and Bureau of Medical Assistance personnel met and established a refund for providers earnings exclusively of $158,159.12 based on input from the provider under discussion.

RESULTS

A. The provider was suspended from the program and has not yet paid total of $158,159.12 refund.

B. Case open. Investigation continuing. Possible indictment pending.

TAB I

PRACTITIONER: SUMMARY INVESTIGATION REPORT

(Case No. 11–72–2)

CASE BACKGROUND

A. *Reason for case initiation.*—Routine screening of billing submitted by provider disclosed an unusually high volume of billings for "home visits."

B. *Previous claims review.*—October 4, 1971, a Blue Shield medicaid audit performed. In a sampling of 34 claims, no overutilization or discrepancies were found by them.

C. *Claims review period and volume:*

1. Claims review period October 1, 1972 through March 5, 1973 (over 500 claims review).
2. Volume of payment during time period, $82,774.09.

CLAIMS REVIEW FINDINGS

A. This provider's practice consisted only of home visits. The physician has no office where he practices medicine.

B. This physician was one of a number of physicians enrolled in the Detroit City Physicians Medical program. This program provides a telephone service for people in need of medical treatment. If the recipient is on medicaid, the physician bills this program. If not, the physician bills the City Physicians Office.

C. It was found that on initial calls received through the City Physicians Office, this physician left a call card directing further calls for medical treatment be referred to his answer service (a machine attached to his telephone at his home residence).

D. Review of claims established that medicaid program was billed for as high as 140 home visits per day.

E. Investigation in the field in contact with many recipients revealed that:

1. This physician starts work at approximately 6 a.m., making house calls from a route established at his "office" the previous afternoon. He is accompanied by a bodyguard, driver, and report writer. At approximately noon each day, he picks up his "second shift" driver, calls his answering service and routes his afternoon calls.

2. Visits were verified with dozens of recipients whom all "swore by the doctor."

3. The quality of care of this physician was referred to his medical association and on at least one occasion a member of that association along with a physician from the Michigan Department of Public Health, at this agency's request accompanied this provider on his daily rounds.

4. This physician may see as many as 8 to 10 recipients at a given address or household, each being billed separately. Generally they are in the same family.

F. This department nor the association representatives could establish if there was a substandard level of care given in this unique medical practice.

RESULTS

As a result of this investigation, a practitioner manual change was effected as follows:

Previously, physicians were paid for home visits on a basis of $15 per home visit.

The basic fee was lowered from $15 to $10 per house visit.

In addition, when there are multiple recipients seen at the same address, the program now only pays $2 for each additional recipient at an address.

B. The change in the manual affected as a result of this investigation has saved untold thousands of dollars in the future of the medicaid program.

C. Case closed.

TAB J

PRACTITIONER: SUMMARY INVESTIGATION REPORT

(Case No. 349–734–11)

CASE BACKGROUND

A. *Reason for case initiation.*—This claims review was performed on the basis of the provider receiving a large amount of moneys paid by medicaid for services during the years 1973 and 1974. The provider was determined to be a high volume physician.

B. *Previous claims review records.*—Prior to this claims review, no claims review had been conducted on this provider by either the Michigan Department of Social Services or Michigan Blue Shield, acting as agent for medicaid.

C. *Claims review period and volumes:*

1. Claims review period June, 1973 through December, 1974.
2. Volume of payment during the above time period $267,607.82.

D. *Claims review.*—The claims review was conducted on July 25, 1974.

CLAIMS REVIEW FINDINGS

A. The physician utilized the services of an unlicensed practitioner working as a physician's assistant in the doctor's office. The physician's assistant was seeing the patients, diagnosing their illnesses, and prescribing care and treatment for the people. The physician's assistant was not an enrolled provider in the medicaid program.

B. There were undocumented office examinations billed by the physician to the medicaid program.

ACTION TAKEN

A. The medical records containing suspected handwriting of the physician's assistance were sent to the handwriting expert in this department for analysis.

B. The physician's office was shopped. That is, one investigator from this section posed as a medicaid recipient and did, in fact, receive treatment from the physician's assistant while the physician was not on the premises.

C. This section determined that the physician's assistant was not licensed to practice medicine. In cooperation with the Detroit Police Department, a warrant for arrest was obtained against the physician's assistant.

D. Payments were suspended to this provider.

E. Numerous attempts by this section to meet with the provider and his representative were met with delaying tactics on the part of the provider's attorney.

F. This section was withholding payments to this provider on the basis of noted abuses and projected refund to protect the State and Federal moneys. On March 7, this department appeared in circuit court as a result of a suit filed by the provider. The court upheld the medicaid program's right to protect the program's moneys when abuses were found.

G. On September 9, 1975, a hearing was held in Lansing presided over by an administrative law judge. The hearing was held to determine if the allegations made by the Department of Social Services were, in fact, true and the provider did, in fact, owe moneys to the Department of Social Services for services rendered by a nonenrolled provider.

RESULTS

A. The case is still open pending a decision by the administrative law judge and further civil action which may be taken by the provider.

B. The projected refund for the provider stands at $114,509.39.

TAB K

PRACTITIONER: SUMMARY INVESTIGATION REPORT

(MA Case No. 92–734–2)

CASE BACKGROUND

A. *Reason for case initiation.*—This case was opened on a basis of a routine claims review.

B. *Previous claims review record.*—Prior to this claims review, a review was conducted by Michigan Blue Shield for the year 1969 with a total refund requested of $1,217.65.

C. *Claims review period and volume:*

1. Claims review period October 4, 1972 to December 31, 1973.
2. Volume of payment during claims review period, $82,845.77.

D. *Claims review.*—Claims review was conducted on February 21, 1974.

CLAIMS REVIEW FINDINGS

A. Lack of documentation for completeness of comprehensive history and physical examination.

B. Lack of documentation for services billed medicaid program.

ACTION TAKEN

A letter of refund request was sent to this provider.

RESULTS

This provider reimbursed the medicaid program for nondocumented services, and so forth for $12,410.30. Provider maintains that he performed the services billed although substantiation does not appear in the patient's records.

TAB L

SPECIAL SERVICES VISION AREA (OPTOMETRIST): SUMMARY INVESTIGATION REPORT

CASE BACKGROUND

A. *Reason for case initiation.*—This case was initiated due to a complaint from Technical Services and Support, within the Bureau of Medical Assistance, regarding payment for services not covered by the program.

B. *Claims review period and volumes:*

1. Claims review period March 16, 1973 to June 12, 1975.
2. Volume of payment during above time period, $149,577.29.

CLAIMS REVIEW FINDINGS

A. No recordings are maintained to establish reason for extra charge over usual and customary.

B. No record to document "medical necessity."

C. In violation of Public Act 1909, section R338.263 (has no records to verify eye exam nor use of equipment).

D. Lack of records to satisfy provider agreement (medicaid), "all records necessary to disclose extent of services to recipient under Program."

ACTION TAKEN

A. Interviewed all recipients in sample.

B. "Shopped the provider, e.g. investigator posed as medicaid recipient and obtained services; also posed as cash customer to verify usual and customary charges to public.

C. Suspended all payments to the provider and terminated further participation in the program.

D. Held several conferences with the provider and his counsel.

RESULTS

A. Provider reimbursed the State of Michigan $15,000.

B. Reinstated to the program on a probationary basis.

TAB M

DENTIST: SUMMARY INVESTIGATION REPORT

(Case No. 219–734)

CASE BACKGROUND

A. Case was initiated in October, 1974, as a result of a complaint filed by a prior employee of this dentist's office alleging improper billings to medicaid.

B. *Claims review period and volumes:*

1. Claims review period one—1, 1973 through three—10, 1974.
2. Payment volume during time period, $42,296.

C. *Claims review.*—Claims review was conducted on November 13, 1974.

INVESTIGATION FINDINGS

A. After review of patient medical records, interview with patients, and so forth, the following was found:

1. It was determined that this dentist was billing the medicaid program for services not provided to recipients.
2. Billing the program for services under prior approval which was established to be questionable. Upon review of the individual recipient complaint and problems, statements given for prior approval proved to be inaccurate.

DISPOSITION

A. Further payment of claims suspended.

B. Provider enrollment terminated in April of 1975.

C. Search warrant obtained and further evidence secured from the office of this Provider.

D. In February of 1975, arrest warrant was issued.

E. In February of 1975, preliminary hearing held in court. Bound over for trial.

F. Due to initiation of criminal charges, claims review was suspended pending outcome of criminal charges.

G. July 10, 1975, trial held. Provider found not guilty by judge.

FURTHER DISPOSITION

A. Claims review refund demand reinitiated for the following reasons:

1. Billing for multiple treatments when only one authorized.
2. Billing for multiple oral hygiene instruction—only one authorized.
3. Billing for multiple fluoride treatments within 1-year time period.
4. Billing for services in excess of $150 without prior authorization.
5. Billing for services not documented in patient records.
6. Billing for dentures not actually provided the recipient.
7. Billing for dentures not constructed as authorized.

STATUS

Demand for refund of $9,122.07 to this dental provider presently pending repayment.

TAB N

Laboratory: Summary Investigation Report

(Case No. 431–745–16)

CASE BACKGROUND

A. *Reason for case initiation.*—This claims review was performed on the basis of a report and information received by this agency from Michigan Blue Shield and additional information from provider enrollment services. The problems included:

1. The provider was enrolled as a type 10 (medical doctor) when, in fact, the billings were submitted for those of a laboratory.

2. There were many invoices submitted for payment in the first 2 months of this year, which were rejected and resubmitted in March and April, which resulted in massive double billing errors.

3. A fire in June of 1964 put the lab out of business, but the lab was still accepting lab work from doctors and lab work was being performed at other laboratories although it was reported on this provider's report forms.

B. *Previous claims review records.*—No previous claims reviews were conducted.

C. *Claims review period and volume:*

1. Claims review period January 1, 1975 through May 1, 1975.
2. Volume of payment during the above time period was $315,649.21.

D. *Claims review.*—The claims review was conducted on June 4, 1975.

CLAIMS REVIEW FINDINGS

A. Some records contained the doctor's order sheets specifying what tests to run, however, the majority of the records do not have this information.

B. Many tests which were billed as manually performed tests were actually done on semiautomated equipment.

C. Many lab results were not found on the lab records.

D. Procedure codes were misinterpreted; the wrong code used to bill for certain tests.

E. Double billing resulted from the billing services submitted paid invoices a second time for repayment.

ACTION TAKEN

A. Payments were immediately suspended this provider.

B. Photographs were taken of all laboratory equipment and submitted to the Division of Laboratory Improvement for identification of this equipment and determination on whether or not the tests performed on this equipment would be considered manual or automated tests.

C. Conference was held with this provider and all agreement to search for additional documentation of tests was made.

D. This provider was informed of the errors in billing as well as nondocumentation of laboratory tests accounted for an error factor of 33.77 percent in the claims review and the refund sought by the Department of Social Services was $106,594.74.

FURTHER ACTION TAKEN

A. The provider, as of this date, has not come forward with additional documentation of unverified lab tests. This department continues to hold moneys in excess of $100,000, protecting its refund claim.

RESULTS

A. This case remains under active investigation.

TAB O

Recipient: Summary Investigation Report

(Case No. 377–745–R)

CASE BACKGROUND

A. *Reason for case initiation.*—A complaint was received from a Wayne County caseworker alleging the recipient had sold homestead property for $15,500, verified by the caseworker. This transaction put the recipient over the $1,500 eligibility requirement.

ACTION TAKEN

A. Nursing home charges from September 1973 to June 15, 1975, were checked revealing a total expenditure by medicaid of $11,638.

B. Medical charges to the program were checked. There was a total of $199.53. This increased the total to $11,837.53.

C. The daughter was contacted by the investigator and she agreed to reimburse the State of Michigan for medicaid benefits received while the recipient was ineligible. It was noted additionally an excess savings of $2,162.45 to be used up on private pay making an added savings to the program.

RESULTS

A. $11,837.53 was recovered by medicaid due to recipient ineligibility by reason of concealed funds.

B. $2,162.45 additional savings to medicaid while recipient was on private pay to become eligible. This makes a total benefit to the medicaid program of $13,999.98.

TAB P

Nursing Homes: General Problems Encountered

The medicaid investigation section does not perform claims reviews of nursing homes per se. Nursing homes are reviewed by auditors of the Cost Audit and Rate Setting Division of the Bureau of Medical Assistance. The investigation section works closely with that division and investigates various direct billing providers associated with nursing homes, employed by and/or in nursing homes and investigate all reported cases of alleged fraud related thereto.

The following is a general listing of types of problems or abuses found during investigations to date. It should be noted that the practitioner (physician) category is interwoven throughout all of the following.

PHYSICAL THERAPY

A. Services performed by unskilled aides or unregistered therapists and billed the program as physical therapy.

B. Services not documented in patient records.

C. "Rubber stamp" signature reviews by nursing home physicians.

D. Unnecessary or nonmedically necessary physical therapy billed.

E. Excessive physical therapy given and/or billed.

F. Kickbacks (gifts, percentages, equipment, space, etc.) given to nursing homes by physical therapy firms.

OPTOMETRY

A. "Wholesale" (bed to bed) eye examinations given.

B. Substandard eye examinations given.

C. Inferior materials dispensed to recipients.

D. Services billed not documented in patient records.

E. Specific services not requested by receipient or physician.

PODIATRIST

A. "Wholesale" (bed to bed) services performed under "contract" to nursing home.

B. Specific services not requested by recipients for whom service billed.

C. Kickbacks required by nursing homes by contracting podiatrist (percentage).

PHARMACY

A. Prescription splitting—generating new prescription for medications usually every 10 to 15 days, thus gaining extra professional fees for pharmacy.

This can not be done without a nursing home physician, administrator, and so forth, allowing the unnecessary renewals of prescriptions.

B. Billing for noncovered services (to residents of long-term care facilities).

These services (nonlegend, over-the-counter drugs), are generally covered in Michigan in the nursing home daily rate as a condition of occupancy. The billing of these by the pharmacy amounts to the program paying twice for the same drug or service and represents a tremendous saving to the nursing home, in that they do not have to pay for these drugs of which they have been paid for already in their daily rate by the program.

C. Kickbacks required by nursing homes of the pharmacies to provide the above.

D. Overutilization of medications for nursing home receipients. This benefits both the nursing home and the pharmacy. Again the collusion or knowledge of all persons is required.

E. There are currently 229 pharmacies enrolled in the medicaid program and serving recipients in long-term care facilities. The 229 pharmacies represent only 11 to 12 percent of total pharmacy providers, yet in 1974, they received approximately $15 million of a total of $45 million paid to pharmacy providers. This is one-third of all expenditures in the pharmacy provider area.

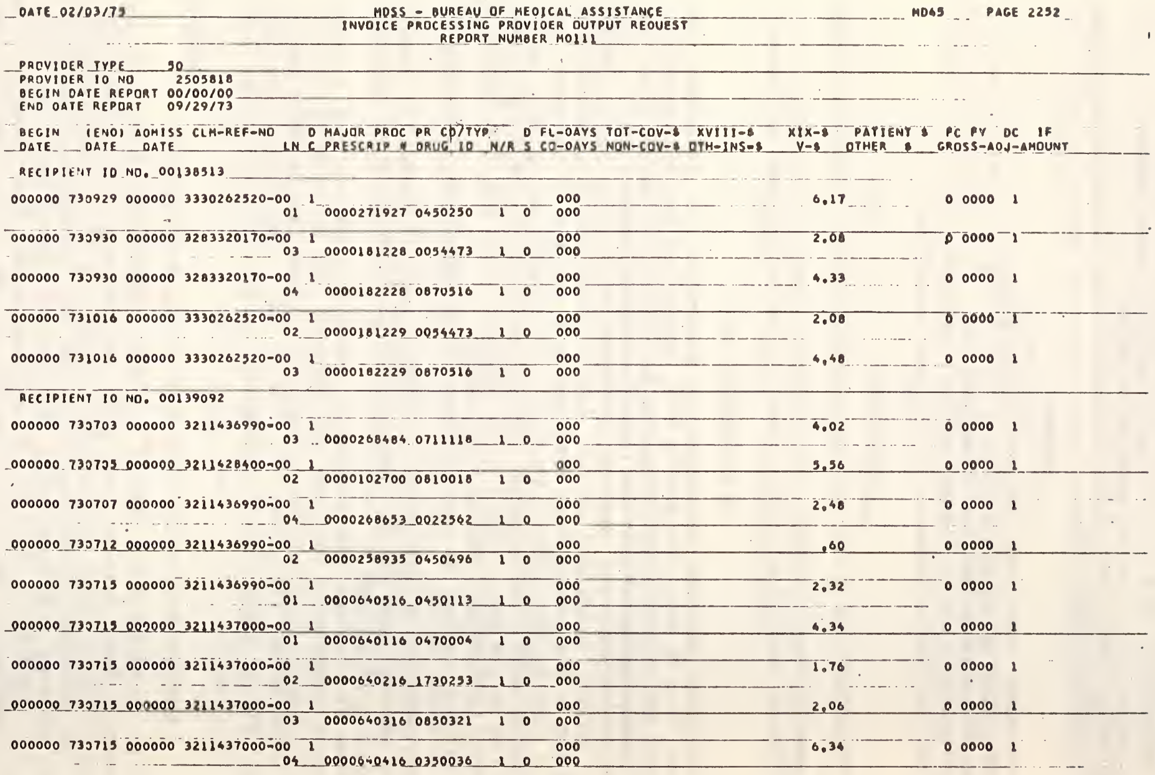
TAB Q

Medicaid Investigation Section: Sampling Techniques

Since the inception of the medical assistance program under the Michigan Department of Social Services (July 1972), the medicaid investigation section sampling techniques have been directly equated to the existent computer ability. The medicaid investigation section has been responsible for numerous updates, upgrades, and complements (i.e. technical, investigative, analytical, qualitative, quantitative, etc.) to this computer ability thus resulting in a uniquely individual system synonymous with only the State of Michigan and the medicaid investigation section. Consequently, this system has shown its significance by generating refunds in magnitudes surpassing all expectations and/or estimates.

The medicaid investigation section is presently in the process of developing a completely new sampling technique, incorporating a completely computerized capability, computer generated, statistically and analytically valid, randomly selective, inclusive of all data pertinent to each provider, recipient, etc.

This process will again be unique and synonymous with only the State of Michigan, medicaid investigation section.



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DATE 02/03/73                         MDSS - BUREAU OF MEDICAL ASSISTANCE                       MD45    PAGE 2252
                                    INVOICE PROCESSING PROVIDER OUTPUT REQUEST
                                               REPORT NUMBER MO111

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 PROVIDER IO NO       2505818
 BEGIN DATE REPORT 00/00/00
 END DATE REPORT   09/29/73

 BEGIN   (END) ADMISS CLM-REF-NO    D MAJOR PROC PR CD/TYP    D FL-DAYS TOT-COV-$  XVIII-$    XIX-$   PATIENT $  PC PY  DC  IF
 DATE     DATE  DATE             LN C PRESCRIP # DRUG ID  N/R S CO-DAYS NON-COV-$ OTH-INS-$    V-$    OTHER  $  GROSS-ADJ-AMOUNT

 RECIPIENT ID NO. 00138513

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                                 01   0000271927 0450250   1  0   000

000000 730930 000000 3283320170-00  1                          000                              2.08             0 0000  1
                                 03   0000181228 0054473   1  0   000

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                                 04   0000182228 0870516   1  0   000

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* For individual Medicaid Providers reports, Medicaid Program activity over a specified time period.

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 DATE 08/18/75                              MDSS - BUREAU OF MEDICAL ASSISTANCE                               MD49      PAGE 421
                                          INVOICE PROCESSING RECIPIENT OUTPUT REQUEST
                                                     REPORT NUMBER MD112

 RECIPIENT ID NO, 17332848
 BEGIN DATE REPORT 00/00/00                                                               REQUESTER CODE 17
 END DATE REPORT   12/27/74
 BEGIN  (END) ADMISS CLM-REF-NO     D MAJOR PROC PR CO/TYP   D FL-DAYS TOT-COV-$ XVIII-$    XIX-$   PATIENT $
 DATE    DATE   DATE               LN C PRESCRIP # DRUG ID  N/R S CO-DAYS NON-COV-$ OTH-INS-$    V-$    OTHER $

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                                 01   0000000000 000        0  0   000

000000 741227 000000 5103285030-00  1            008368 9         000                  2,40       .60
                                 02   0000000000 000        0  0   000

000000 750225 000000 5102469780-00  1            008368 9         000                            3,00
                                 02   0000000000 000        0  0   000

 PROVIDER TYPE 13  PROVIDER ID NO 1075795

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                                 01   0000000000 000        0  0   000

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                                 01   0000000000 000        0  0   000

 PROVIDER TYPE 13  PROVIDER ID NO 1185741

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                                 01   0000000000 000        0  0   000

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 PROVIDER TYPE 50  PROVIDER ID NO 2525875

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* For individual Medicaid recipients reports, services received from specific Medicaid Providers over a specified time period.

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                                   MICHIGAN HEALTH AND WELFARE DATA CENTER
DATE    08/19/75                              PROC-DRUG SUMMARY
PROGRAM NO. FC-14-00                        REPORT NUMBER  FC-010                                   PAGE   37
PAYROLL NO. 34-9

    PROV NAME                          ID/TYPE  1018959/14    TYPE LICENSE 14-02102       REQUESTER NO.  19

PROC-DRUG    NO OF                                   ------D O L L A R S   P A I D   B Y   S T A T E------
CODE-TYPE    CLAIMS                                  TOTAL      TITLE 5   TITLE 5-19 TITLE 19     ALL OTH

        SURGERY
027200-9       36                                  1430.00       .00         .00     1430.00        .00
029040-9       31                                   325.50       .00         .00      325.50        .00
029041-9     2295                                 21581.15       .00         .00    21161.15     420.00

TOTAL        2362                                 23336.65       .00         .00    22916.65     420.00


P-TOTAL      2362                                 23336.65       .00         .00    22916.65     420.00
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* For individual Medicaid Providers reports for a specified time period, reimbursement by program category and sorted by type of service (i.e., surgery, office visits, etc.)

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                                      MICHIGAN HEALTH AND WELFARE DATA CENTER
DATE   08/19/75                                 PROVIDER PROFILE
PROGRAM NO, FC-14-00                         REPORT NUMBER  FC-011                                    PAGE  658
PAYROLL NO, 34-9

     PROV NAME                              TYPE-LICENSE  14-02102                      REQUESTOR NO.  19

RECIP-ID    PROC-DRUG  PROV-ID-TYPE  CLAIM-LINE-NO  DATE-OF  -----D O L L A R S   P A I D   B Y   S T A T E-----
            CODE/TYPE                               SERVICE      TOTAL    TITLE-5   TITLE-5-19   TITLE 19    ALL OTH

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            0290419    1018959  14  436545646000 02 112074       9.45       .00        .00         9.45       .00
            0290419    1018959  14  436545646000 03 112274       9.45       .00        .00         9.45       .00
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            0290419    1018959  14  436545647000 01 112774       9.45       .00        .00         9.45       .00
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* For individual Medicaid Providers reports for a specified period of time: Medicaid services rendered to specific Medicaid recipients.

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DATE: 08/28/75                                     MICHIGAN DEPARTMENT OF SOCIAL SERVICES                                    PAGE  920
                                                   INVOICE PROCESSING PROVIDER SAMPLE

PROVIDER NO: 2510881                               REPORT NO: EZ-017
PROVIDER TYPE: 50                                  TIME PERIOD: 01/01/74 TO 12/31/74

DRUG-ID    ---------------- RANDOM SAMPLE -----------------    ---------------- HISTORICAL FILE ----------------
             CLAIMS   PERCENT   CUM. %   AMNT PAID      MEAN      CLAIMS   PERCENT   CUM. %   AMNT PAID      MEAN

                  1      1.00    88.00  $     7.15  $   7.15          29      0.48    88.95  $   144.73  $   4.99
0840173           0      0.00    88.00  $     0.00  $   0.00           0      0.00    88.95  $     0.00  $   0.00
0840174           0      0.00    88.00  $     0.00  $   0.00           0      0.00    88.95  $     0.00  $   0.00
                  0      0.00    88.00  $     0.00  $   0.00          16      0.27    89.22  $    41.79  $   2.61
0850001           0      0.00    88.00  $     0.00  $   0.00           1      0.02    89.23  $     2.88  $   2.88
0850033           0      0.00    88.00  $     0.00  $   0.00           3      0.05    89.28  $     9.53  $   3.18
                  2      2.00    90.00  $     7.36  $   3.68          20      0.33    89.62  $    89.55  $   4.48
0850115           0      0.00    90.00  $     0.00  $   0.00           0      0.00    89.62  $     0.00  $   0.00
                  1      1.00    91.00  $     5.80  $   5.80          45      0.75    90.37  $   272.49  $   6.06
0858163           0      0.00    91.00  $     0.00  $   0.00           3      0.05    90.42  $     9.82  $   3.27
                  0      0.00    91.00  $     0.00  $   0.00          12      0.20    90.62  $   108.15  $   9.01
0870543           1      1.00    92.00  $     5.60  $   5.60          20      0.33    90.95  $   126.70  $   6.34
0870544           0      0.00    92.00  $     0.00  $   0.00           0      0.00    90.95  $     0.00  $   0.00
0870575           0      0.00    92.00  $     0.00  $   0.00           0      0.00    90.95  $     0.00  $   0.00
                  0      0.00    92.00  $     0.00  $   0.00           4      0.07    91.02  $    13.82  $   3.46
0870715           0      0.00    92.00  $     0.00  $   0.00           0      0.00    91.02  $     0.00  $   0.00
                  2      2.00    94.00  $    17.19  $   8.60         118      1.97    92.99  $   774.10  $   6.56
0881555           2      2.00    96.00  $    14.53  $   7.27         101      1.69    94.68  $   714.62  $   7.08
                  1      1.00    97.00  $     6.57  $   6.57          31      0.52    95.19  $   172.62  $   5.57
0890235           0      0.00    97.00  $     0.00  $   0.00           2      0.03    95.23  $    10.01  $   5.01
                  1      1.00    98.00  $     7.00  $   7.00          72      1.20    96.43  $   334.44  $   4.65
1672120           0      0.00    98.00  $     0.00  $   0.00           5      0.08    96.51  $    12.75  $   2.55
1672121           0      0.00    98.00  $     0.00  $   0.00           0      0.00    96.51  $     0.00  $   0.00
1672416           0      0.00    98.00  $     0.00  $   0.00          17      0.28    96.80  $    45.25  $   2.66
1722017           0      0.00    98.00  $     0.00  $   0.00           0      0.00    96.80  $     0.00  $   0.00
                  1      1.00    99.00  $     5.58  $   5.58          60      1.00    97.80  $   239.03  $   3.98
4841904           0      0.00    99.00  $     0.00  $   0.00          18      0.30    98.10  $   132.37  $   7.35
                  0      0.00    99.00  $     0.00  $   0.00          51      0.85    98.95  $   428.72  $   8.41
5980533           0      0.00    99.00  $     0.00  $   0.00           3      0.05    99.00  $    15.75  $   5.25
                  1      1.00   100.00  $     1.17  $   1.17          60      1.00   100.00  $   269.33  $   4.49

                100                     $   511.18  $   5.11        5990 (15.56 CLMS/RECIP)  $ 31995.18  $   5.34
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* For individual Medicaid Providers or recipients, reports for a specified time period:

1) Randomly selected types of Medicaid services.
2) The degree to which these services were billed the Medicaid Program.
3) The amounts (average and cumulative) paid for each of these types of Medicaid services.

TAB S

MEDICAID PROVIDER ADMINISTRATIVE REVIEW PROCESS

Michigan Department of Social Services
Bureau of Medical Assistance
Program Integrity Division
Medicaid Investigation Section

Providers who have been requested to refund monies to the Medicaid Program have a four (4) step review process at their disposal.

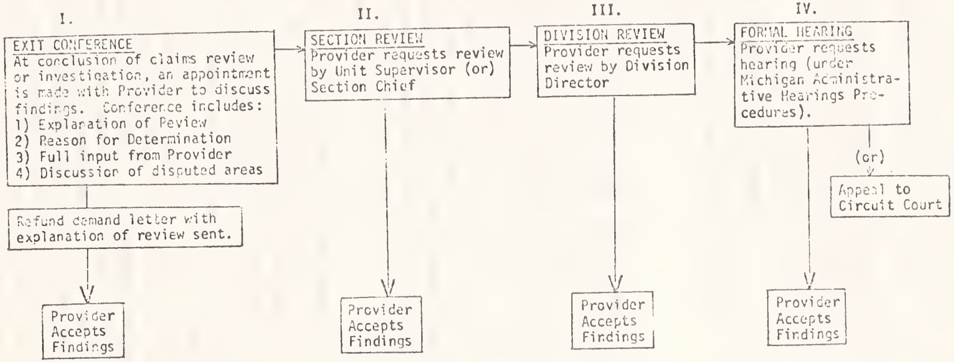
a) In proceeding to each step, the Provider must include the reason(s) in writing, for disagreement and the specific areas to be discussed and reconsidered.

b) The Department shall reply in writing, setting time, date and place of review or hearing.

c) The Provider shall, at all review levels, be able to examine work papers, question Program representatives, present documents or proofs to establish his position, represent himself or have someone speak and/or represent him.

d) The Provider will be given a minimum of 15 days at each level of review.

e) The Provider will be advised in writing of the findings of each review level.


I.
EXIT CONFERENCE
At conclusion of claims review or investigation, an appointment is made with Provider to discuss findings. Conference includes:
1) Explanation of Review
2) Reason for Determination
3) Full input from Provider
4) Discussion of disputed areas
Refund demand letter with explanation of review sent.
Provider Accepts Findings
II.
SECTION REVIEW
Provider requests review by Unit Supervisor (or) Section Chief
Provider Accepts Findings
III.
DIVISION REVIEW
Provider requests review by Division Director
Provider Accepts Findings
IV.
FORMAL HEARING
Provider requests hearing (under Michigan Administrative Hearings Procedures).
(or)
Appeal to Circuit Court
Provider Accepts Findings

NOTE: Review levels II. and III. are optional and may be waived in writing by the Provider.

Appendix 2

NEWSPAPER ARTICLES SUBMITTED BY WILLIAM CRAWFORD[1] AND WILLIAM GAINES[2] REPORTERS, CHICAGO TRIBUNE

[From the Chicago Tribune, Sunday, Sept. 7, 1975]

BARE PATIENT NEGLECT AT VON SOLBRIG HOSPITAL—SHORT ON STAFF, LONG ON DIRT

TASK FORCE REPORT

Chicago's only for-profit general hospital, von Solbrig Memorial, is one doctor's personal fiefdom where financial shortcuts go hand in hand with unsafe and unsound medical practices. Filth, dangerous understaffing, and violations of city and state regulations uncovered there are detailed in this, the first of a series, by Task Force Director Pamela Zekman, and reporters Jay Branegan, William Crawford, and William Gaines.

It is a critical period for the 6-year-old girl lying in an anesthetized sleep on the operating table in von Solbrig Memorial Hospital. Only minutes ago she had undergone two operations, a tonsillectomy and surgical repair of a hernia.

But the only other person in the operating room is a $2-an-hour janitor, in his unsanitary working clothes, who has just put down his mop in the corridor outside and rushed in to watch over the young patient at the request of a nurse.

The surgeon, the nurses, nurses' aides, and the anethesiologist have all gone. And for several moments, until the nurse returns to relieve him, the janitor is in charge of the patient.

The janitor is *Tribune* task force reporter William Gaines, who found himself summoned into the operating room as many as six times in a single week, often in soiled clothing, to assist patients at Chicago's only for-profit general hospital.

Gaines was a member of a task force investigating team that found the 83-bed hospital at 6500 S. Pulaski Rd. poorly maintained, understaffed, and in apparent violation of medical standards and city and State regulations.

"That's the grossest type of mismanagement I've ever heard," Dr. Hugh Firor, head of pediatric surgery at Cook County Hospital, said when told of Gaines' aid to the young tonsillectomy patient. Firor said the girl could have inhaled blood into her lungs.

Other doctors said cardiac disturbances or hemorrhaging could strike in the time right after surgery.

And Edward King, assistant commissioner of the Chicago Board of Health, said the use of a janitor in the operating room simply "breaks sterile technique."

During the several weeks that Gaines worked in the hospital, he and other reporters found:

The emergency room licensed by the city as a "basic emergency care" facility often has no doctor specifically assigned to emergency-room duty, as required by city and State codes.

Only 18 of 50 doctors listed as staff members actually practice at the hospital. The others have left the State, ceased practicing at the hospital years ago, never practiced there, or are dead.

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[1] See statement, p. 58.
[2] See statement, p. 67.

An elderly patient, a cast around her chest, wept daily from pain and frustration as untrained hospital personnel, including janitors, struggled to lift her from her wheelchair to her bed. Most hospitals have trained personnel and bedside lifts for such tasks.

Urine was allowed to stand for hours on the floor of a patient's room. The urine was cleaned up only after the reporter-janitor was called into service because the janitor on duty had been ordered to paint the hospital owner's cabin cruiser.

Patients with private health insurance were admitted for long stays in vol Solbrig after other hospitals and doctors had pronounced them healthy. One man was operated on after three doctors told him he was in good enough health to return to work.

The responsibility for conditions in the hospital rests with Dr. Charles R. von Solbrig, 68, the hospital's sole owner and director. He controls every facet of the operation from hiring the lowest employe to surgery, just as he has from the hospital's founding, when he helped build the structure with his own hands. It was Dr. von Solbrig who personally hired Gaines as a janitor.

The hospital last October lost its accreditation from the Joint Commission on the Accreditation of Hospitals, but Dr. von Solbrig continues to operate the 16-year-old facility on licenses from the Chicago Board of Health and the Illinois Department of Public Health. Either agency has authority to close the hospital.

In 1964, Dr. von Solbrig pleaded no contest to a Federal indictment charging that he had evaded $44,612 in income taxes. He was placed on probation for 3 years and permitted to keep his medical license.

The Illinois Department of Registration and Education has been investigating complaints involving his treatment of patients.

For the doctor, running Chicago's only proprietary [for-profit] general hospital is a business. Reporters found Dr. von Solbrig to be a cost-conscious administrator who fails to keep an adequate number of nurses, aides, and orderlies on the payroll. As a result, inexperienced persons were thrown into jobs normally done by trained medical personnel.

Gaines saw nurses' aides routinely used to awaken patients after surgery and return them to their rooms, a violation of State regulations that require them to be attended by a registered nurse and released by a doctor.

The reporter once was called from his janitorial duties into the recovery room to hold down the arms of a patient while a crew of nurses and doctors labored to save the patient's life.

One day when Gaines was at the hospital on his day off, he was called into the operating room in his street clothes to help lift a heavy patient. On three occasions, Gaines was ordered to don a lead smock and to hold elderly patients in position for X-rays.

At von Solbrig, he found, there was only one orderly, an unpaid, untrained 16-year-old who within 3 days on the job was working as an assistant in the operating room. He bragged to a *Tribune* reporter and to his parents, who are friends of Dr. von Solbrig, that he was "really into some heavy surgery."

The youth said he washed and scrubbed patients before surgery; assisted the nurses and doctors during appendectomies and stomach and intestinal operations, and helped the nurses insure that all the surgical sponges were removed from patients following surgery.

The hospital was short of personnel one Saturday afternoon that the entire hospital staff consisted of Dr. von Solbrig, one registered nurse, one licensed practical nurse, and three nurses' aides. The nurses' aides. The nurses complained that they were ragged from the workload. Some of the five emergency cases that day had to wait while the medical staff tended patients in the rooms.

The next day, when emergency cases were lined up waiting for care and the staff shuttled between patients' rooms and the emergency room, Gaines had to assist nurses when an elderly woman patient choked and fell to the floor.

When interviewed by *The Tribune*, Dr. von Solbrig refused to disclose how many registered nurses he employs. "That's not your business," he said.

Regarding the staffing observed that Saturday, Dr. von Solbrig insisted, "Every floor has a registered nurse at every station—on every three stations—every day. No exceptions. If you didn't see them here, they were here; don't you dare say they weren't here because they were."

With that, the doctor stalked out of the interview, leaving behind his lawyer, his public relations counselor, and two other employees. He has refused to answer further questions.

One of the unanswered questions concerned the emergency room, which under city regulations should have at least one licensed doctor on specific emergency-room duty at all times. That doctor "may not be assigned to any other duties," a Chicago Board of Health spokesman said.

But von Solbrig hospital is staffed at night by a lone resident who must split his duties between the emergency room and the resident patients.

And during the day it was not uncommon for Dr. von Solbrig to be the only physician on the premises, yet tied up with office patients or surgery.

For example, Dr. von Solbrig had left the hospital to march in a parade the day Mrs. Claire Gleffe, 6016 S. Keeler Ave., came to the emergency room with a badly stubbled toe. She was seen by a nurse and an X-ray technician, who successfully put a splint on her foot.

The only doctor on the premises while Dr. von Solbrig was absent for several hours was Dr. Lewis Silver, the radiologist, who does not qualify under Board of Health standards as the emergency room doctor, a spokesman for the board said.

The hospital bill for the services included a $7.50 doctor's fee, Mrs. Gleffe said no doctor treated her.

"I paid the $24 for the X-ray and the other things, but I never saw a doctor, so I'm not going to pay it," she said in an interview, "It isn't the money, it's principle. Hospitalization would have paid for it. I just like justice."

The Tribune found cleanliness and sanitation at the hospital suffered because the small maintenance staff often was further depleted as janitors were ordered to run personal errands for Dr. von Solbrig.

"It's too busy on the floor today," Gaines was told by one elderly coworker who had sole responsibility for cleaning the first floor. "I can't handle it all. Then the doctor had me wash his car. I don't know if I can get it all done."

Gaines found that insects abounded in the hospital and discovered a fertile breeding ground for them in a damp closet where rolls of toilet paper were stored. He washed walls that apparently hadn't been washed in years, and swept cobwebs from behind the doors of patients' rooms.

But economy through thin staffing is only one side of the balance sheet. Each day a patient stays in the hospital, which has numerous vacant beds, adds to its income.

The Tribune found that some patients were admitted for stays of a week and more after other doctors said they needed no hospitalization.

The family of Mahmoud Hassan, 45, including his wife, Bakrish, 38, his son, Fairs, 2, and his father, Farhat, 70 came to von Solbrig the day after they had been involved in what police termed a minor traffic accident in southwest suburban hometown. A tractor cab had bumped them from behind when the Hassan car made a false start at a stop light, according to police.

"There's no way in the world that accident could have caused excessive damage . . . it was just a tap," said Hometown Patrolman Wendell Flint, who witnessed the incident.

The whole Hassan family was taken to Christ Community Hospital in Oak Lawn, where they were examined and X-rayed by staff doctors. They complained of pains in the back and neck and were released with instructions to apply heat the the sore spots, according to hospital records.

But the next day they were admitted to the von Solbrig Memorial Hospital after being examined by Dr. von Solbrig. Mrs. Hassan left after a week with the child, who spent most of his confinement toddling up and down the second-floor halls, playing with his toys, and throwing a tennis ball against the wall. The men left a week later.

The family spent much of their time walking about, chatting, reading, and visiting Osama Betouni, 21, who spent 33 days in the hospital under Dr. von Solbrig's care after he had been examined by three other doctors who found him to be healthy.

Betouni, of 5315 S. Damen Ave., said he hurt his back while working at the Sweetheart Cup Co., where he is a forklift driver. The company physician prescribed hot packs and other simple treatment, but Betouni said the pain persisted.

Betouni then went to a specialist at Christ Community Hospital for muscle and nerve tests. "They didn't tell me anything," Betouni said of the negative test findings.

The company then sent Betouni to a Loop industrial surgeon in the office of Dr. W. A. Clohisy, 120 S. La Salle St., where he was again given a thorough examination and told he could report back to work. Among the ailments the doctor looked for and ruled out was a possible hernia.

After a week back on the job, Betouni was still complaining of the same injury. He went to von Solbrig hospital.

Dr. von Solbrig admitted Betouni, who is covered by a Blue Cross major medical policy, and a week later operated on him for a double hernia.

Betouni's only complaint while he was in the hospital was his long stay after the operation.

"I know other guys who have had the same operation and they go home in a few days," he told janitor-reporter Gaines. "I've been here more than a month. I think it's because I got good insurance."

[From the Chicago Tribune, Sunday, Sept. 6, 1975]

Grimy Hands Hold Life In Balance

(By William Gaines)

"Hey Bill, come in here. Hurry," a nurses' aide hisses to me.

I drop my grimy rag and stride across the hall to the recovery room next to surgery.

"Hold his hand, he keeps lifting it up," she commands in a harried and anxious voice, pointing to the beefy arm of a 68-year-old man who has just been wheeled semiconscious from the operating room.

I hold one, then the other to stop the patient from pulling loose the tubes that are feeding plasma and sterile water into his body. He writhes on the cart. The aide scurries nervously around the room, getting supplies and checking the bottles.

I was a task force reporter, hired as a janitor at the von Solbrig Memorial Hospital, 600 S. Pulaski Rd. I had been employed to scrub and mop and throw out garbage, not to assist nurses and doctors in the sterile surgical area.

The man does not respond to treatment. Other aides, nurses, and a doctor come to assist us.

Suddenly he appears to stop breathing. His whole body goes limp. His arms relax under my grip.

The medical personnel—the only ones who are supposed to be here, I think defensively—pry his mouth open and keep the passage to his throat clear with a short plastic cylinder. Down his mouth they shove a tube to begin administering oxygen.

The characters in this hectic scene now crowd the room—nurses, nurses' aides, an orderly, all antiseptically scrubbed in white clothes. And me in my filthy janitor's outfit. Half the hospital's skimpy staff is here.

The nurses and doctor are speaking tensely, occasionally snapping an order while monitoring the patient's vital signs. His chest heaves tentatively, then again, stronger.

A lab technician crowds in next to the man to inject a stimulant.

"You there," someone says to me after the hypodermic needle is extracted, "hold that cotton on his arm there." I do so, with the same hand I'd used to wring dirty water from my mop only a few moments earlier.

Thirty minutes after I called in, the old man is wheeled back into surgery. To me, unexperienced in the daily medical drama of hospital life, it felt like hours, I am drenched with sweat.

The patient, I learned later, recovered.

The experience was frightening to me; it was depressing, for I knew that it was not just a fluke that I, a janitor, had been called on to do the work of trained orderlies and nurses' aides.

It happened to me almost daily at von Solbrig hospital, where I had been hired at $2-an-hour by the hospital's owner, administrator, and medical director, Dr. Charles R. von Solbrig.

At least there were other people with me through that medical emergency. A few weeks later I was the sole guardian of a child during a critical period following surgery.

The child, a 6-year-old girl, had undergone a tonsillectomy and corrective surgery for an umbilical hernia in the operating room, a few feet from where I was mopping the second-floor corridor.

The operations had just been completed and the anesthetist, a nurse, and a nurses' aide filed past me and disappeared around the corner.

"Bill," a nurse called to me, "c'mere a minute." I put down my mop and entered the operating room.

The nurse was standing next to a small girl lying nearly motionless under a sheet, breathing slowly, in an anesthetic sleep. The operation had ended only minutes before, which meant the youngster was in the post-operative stage when complications are likely to occur.

"This is a critical time," Dr. Jack L. Paradise of Children's Hospital in Pittsburgh, one of the Nation's leading experts in tonsillectomies, told me later. "There can be cardiac disturbances. There can be breathing problems that heighten the risk of cardiac disturbances. There is a danger of hemorrhaging. The child could aspire blood [breathe it into the lungs].

Instead there was me, the janitor. My instructions from the nurse: "Stand there." Then she was gone.

The little girl and I were alone in the room, both of us helpless. I swore under my breath. It was a responsibility I didn't want. But I couldn't walk out.

Nothing went wrong during the nurse's brief absence, but I had been placed in that situation because the tight-fisted staffing policies at Chicago's only for-profit general hospital don't provide for enough nurses, aides, or orderlies.

Once when I came into the hospital on my day off, a nurse called to me from the operating room as I stood in the hallway in my street clothes, "Come in here a minute, we need some help."

I walked, virtually off the street, into the operating room. "Sir, you get on that end, hold on here," she said to me, trusting into my hands the corner of a sheet that was under a large woman on the operating table. The patient was still unconscious, and too heavy for the nurses and lone orderly to move.

It finally took six people—five working hospital employees and me—to move the woman onto her wheeled cart.

One duty we janitors had to perform almost daily was to lift an elderly woman from her bed into a wheelchair and put her back in bed again later in the day.

It was a delicate task, for her shoulder was in a cast and her left arm was blue and swollen. A trained orderly or licensed practical nurse probably could have found a way to lift her without inflicting excruciating pain.

We janitors never did. "I'm falling," the frail woman would cry in fear as we clumsily maneuvered her. Once she slid out of the wheelchair onto the floor. Another time she fell into the wheelchair when she slipped from an aide's grip. Her pain was nearly unbearable and she cried:

"Why don't you take me out and shoot me?"

ONLY 18 OF 50 'STAFF' PRACTICE AT HOSPITAL—4 DOCTORS ON LIST DEAD

Although 50 doctors are listed on the staff director at the von Solbrig Memorial Hospital, only 18 of the 47 located by *The Tribune* said they practice there.

At least four of the doctors on the list are dead. One has been dead for 4 years.

Nothing could be learned about three doctors. They are not listed in the American Medical Association's national directory or in any Chicago-area telephone directory.

Some of those contacted were mystified how their names got on the staff list of the hospital, owned by Dr. Charles R. von Solbrig. "I never applied for the staff and as far as I know, I'm not on it," said Dr. Frank J. Padour, whose name appears on the list as "Dr. F. Padour." He's the only physician named Padour in the Chicago area.

"I have my boat moored near his [Dr. von Solbrig], and I wave to him when I see him," Padour said, explaining his only possible connection with the hospital. "He may have my name up there for decorative purposes. He probably just thought he wouldn't mind having all those doctors on the staff."

Other doctors' reactions to the news that they were among von Solbrig's "staff doctors" included:

Dr. Theodore Drugas, 3759 W. 95th St., Evergreen Park, a surgeon at Holy Cross Hospital: "That's unusual, because I haven't been there for 15 years."

Dr. Constance O'Britis, 2408 W. 63d St., retired as a surgeon, still in general practice: "I don't think I had a single patient there . . . I don't think I even ever set foot in there."

Dr. Arnold Kaplan, 104 S. Michigan Ave. "I haven't been there for 7 or 8 or 9 years. Gee, it's been a long time.

Dr. Kostas Koinis, 3840 W. 95th St., Evergreen Park, a pediatrician: "I sent several letters telling them I resigned from the staff and haven't paid any staff dues for 10 years."

Dr. A. F. Montezon, 9630 S. Longwood Dr.: "I can't help it if my name is still on that directory. I have not been going there for 10 to 12 years."

Dr. John A. Sanfilipo, 10522 S. Cicero Ave., Oak Lawn: "It's not true. It's ancient . . . once, many years ago, I took an emergency patient there. I think a patient of mine told me my name was up there."

Dr. Algrid Pautienis, Santa Monica, Cal.: "I am not associated with that hospital anymore . . . not since I left Chicago in 1966. My name shouldn't be up there. Remove my name."

PROBE STARTED AT VON SOLBRIG

(By William Gaines and Jay Branegan)

Investigations into von Solbrig Memorial Hospital and two of the doctors who practice there were ordered Monday by city and State agencies in the wake of *Tribune* disclosures of alleged unsafe and unethical medical practices at the hospital.

The Chicago Board of Health held an emergency hearing Monday morning at which the owner of the hospital, Dr. Charles R. von Solbrig, was ordered to appear. The hearing was requested by Dr. Eric Oldberg, president of the Board of Health, on the basis of *Tribune* stories Sunday and Monday that documented routine violations of State hospital licensing codes administered by the city.

Ronald Stackler, director the Illinois Department of Registration and Education, ordered an immediate investigation into the practices of Dr. Edward J. Mirmelli, a physician who performs wholesale, assembly-line tonsillectomies at von Solbrig hospital, 6500 S. Pulaski Rd.

The State Department also announced it was expanding its investigation of malpractice charges against Dr. von Solbrig to include other allegations made in *The Tribune*.

"The department intends to thoroughly investigate all the allegations made in *The Tribune* about Dr. von Solbrig, Dr. Mirmelli, and any other licensed medical personnel working there," a spokesman said.

The Department of Registration and Education could ask the State medical licensing committee to revoke a doctor's license.

At the Board of Health hearing at the Civic Center, Dr. von Solbrig denied that a *Tribune* reporter, working as a janitor in the hospital, had been left along with an unconscious patient following surgery, as disclosed in *The Tribune* Sunday.

Thomas J. Cooney, executive director of hospital administration for the Board of Health, told Dr. von Solbrig to bring in hospital payroll records Tuesday after the doctor's attorney requested that the hearing be continued until then. The next hearing will be held in the Board of Health hearing room, in the Civic Center, at 11 a.m. Tuesday.

Cooney quoted from *The Tribune* series that Gaines and other janitors were routinely called into the surgery room. "We can check the records. Bring your payroll records in," Cooney told Dr. von Solbrig.

During the task force investigation, reporters found patients routinely hospitalized for long stays by Dr. von Solbrig when other doctors had pronounced them healthy.

Public aid families with three to five children were subjected to apparently unnecessary tonsillectomies by Dr. Mirmelli. Medical experts said the odds are astronomical that an entire family would need their tonsils out at once.

Von Solbrig Hospital, Chicago's only for-profit general hospital, lost its accreditation last October from the Joint Commission on the Accreditation of Hospitals, a private organization sponsored by the hospitals themselves.

Dr. von Solbrig, sole owner of the hospital, appealed the loss of accreditation, which is accepted by the Illinois Department of Public Health in lieu of a thorough accreditation process of its own.

The JCAH in April upheld its original decision to withdraw accreditation, but the State did not inspect the hospital until late July.

The results of the State inspection have not been compiled or released yet, according to a spokesman for the Public Health Department.

[From the Chicago Tribune, Sept. 8, 1975]

SURGERY DONE ON ASSEMBLY LINE BY VON SOLBRIG PHYSICIAN

TASK FORCE REPORT

Questionable operations and tests are carried out on welfare patients on a medical assembly-line basis at von Solbrig Memorial Hospital, a Tribune task force investigation has found. This is the second in a series by Task Force Director Pamela Zekman and reporters Jay Branegan, William Crawford, and William Gaines.

Von Solbrig Memorial Hospital is the haven of a West Side physician who uses its facilities to reap thousands of dollars annually from the welfare system with assembly-line tonsillectomies on entire welfare families.

The odds are astronomical, medical experts say, that several children in the same family would need their tonsils removed at once. But for $120 an operation, Dr. Edward J. Mirmelli defies the odds, *The Tribune* task force found.

Reporters discovered he regularly operates on three, four, and five children from the same welfare families in von Solbrig, 6500 S. Pulaski Rd., helping boost his welfare income to $60,000 last year, and $124,000 in 1973, according to Federal Government figures.

The wholesale tonsillectomies at von Solbrig are only one example of questionable welfare costs at the hospital, which *The Tribune* disclosed Sunday is understaffed, poorly run, and dirty. Interviews with patients and examination of State Department of Public Aid records by the task force also found that:

A $19 electrocardiogram [EKG] is ordered for virtually every public aid child admitted for major or minor surgery, even though medical authorities say such a heart test on a child with no history of cardiac problems serves no medical purpose.

Circumcisions are routinely performed on children from welfare families although many doctors say there is no medical reason to do so.

Each time a public aid patient undergoes surgery at von Solbrig, a charge of $13 is recorded for the "recovery room." Many of these patients were observed being merely wheeled through there on the way back to their rooms.

Children on public aid are given—and the taxpayer is charged for—what doctors say are needless chest X-rays prior to such unrelated operations as circumcisions and tonsillectomies.

Each test and operation adds to the cost of the average stay for a welfare patient at the 83-bed von Solbrig hospital. Using a formula based on this average stay, public aid pays the hospital a flat fee of $89.16 a day for each welfare patient, exclusive of doctors' fees.

The Tribune disclosed Sunday that von Solbrig, the city's only for-profit general hospital, is poorly maintained and so understaffed that janitors are regularly assigned the tasks of trained personnel, including assisting in the operating room. Many routine hospital practices violate medical standards and city and State regulations, the task force investigation found.

The owner of the hospital, Dr. Charles R. von Solbrig, 68, has few public aid patients of his own, but the hospital gets a steady stream from his long-time associate, Mirmelli.

Mirmelli, 63, of 3150 N. Lake Shore Dr., has been a staff physician with the hospital since it opened in 1959 and was on the original executive committee.

He is under county indictment charging attempted theft by deception when he was medical director of a North Michigan Avenue abortion clinic that was closed by a circuit court order last year.

Mirmelli has an office at 3814 S. Kedzie Ave., but gets the bulk of his welfare patients from his office at the Great West Medical Clinic, 3711 W. Roosevelt Rd., in the heart of the West Side ghetto.

He practices at the clinic 3 days a week, seeing as many as 100 patients a day. "He calls them into his office like a herd of cattle," said Mrs. Daphne Oden, of 1502 S. Homan Ave., a former patient who now takes her children elsewhere.

It is during these office visits—when some patients say, Mirmelli spends only 2 minutes examining each child—that he makes the decision to extract a family's tonsils.

The decision is a frequent one, *The Tribune* found. In 2 weeks during April Mirmelli performed 14 tonsillectomies at von Solbrig hospital. Included were two families with five children each. Other months showed similar patterns.

Such prodigious surgery is not matched even by mammoth Cook County Hospital where, according to Dr. Ludwig Stemmer, head of the ear, nose, and throat department, the six specialists together perform only two to four tonsillectomies a week.

"There simply are not situations in which whole families have their tonsils out," he said.

The odds are "one in a million" that a family of five would all need their tonsils out at the same time, agreed Dr. John Raffensperger, division head of the department of surgery at Children's Memorial Hospital.

Seven physicians and ear, nose, and throat specialists consulted by *The Tribune* agreed it was nearly impossible for so many members of the same family to require tonsillectomies at the same time.

They said an attack of tonsilitis involves a severe sore throat and usually loss of hearing as well as high fever and draining of the ears.

Even if a case is diagnosed as genuine tonsillitis, "any child deserves a course of conservative management before an operation is given," Stemmer said. Surgery is not called for unless a child has repeated tonsillitis attacks, from three annually for 3 years to seven in 1 year, he said.

Mirmelli gets $120 from the State for every tonsillectomy he performs.

In a 6-hour surgical tour de force last May 15 that netted him about $600, Mirmelli operated on each of the five children of Mrs. Mary Adam, of 4136 W. 21st Pl., in most cases performing several operations on each child:

Mark Adam, 6—repair of umbilical hernia, removal of tonsils and adenoids.
David, 10—removal of tonsils and adenoids.
Perry, 11—circumcision, removal of tonsils and adenoids.
Terry, 12—circumcision, removal of tonsils and adenoids.
Oliver, 15—circumcision, removal of cyst from eyelid, removal of tonsils.

"That's like a Hollywood spectacular," said Dr. Robert Miller, head of the pediatrics division at Cook County Hospital. "That kind of practice should have gone out after the last world war. I don't have any sympathy for that kind of practice."

The Illinois Department of Public Aid paid $2,047.32 in hospital bills for the family, not including Mirmelli's charges.

Mrs. Adam said the youngest child, Mark, never complained about a sore throat, and he did not have the usual symptoms that doctors say call for surgery. She told *The Tribune* she repeatedly questioned Mirmelli about the necessity of operations on all five children.

But in the end, she said, "I had to trust the doctor completely.

"He told me when they got older it would be worse on them. It's better for children to take them out, when they are younger. He said I might as well do it for them now," she recalled.

One month earlier, Mirmelli extracted the tonsils of all five children of Robert and Mary Lou Lawler, of 5476 S. Menard Ave., patients from his Kedzie Avenue office, although the parents said only one of the children had repeated tonsillitis attacks.

The hospital was paid $1,337 for services provided the Lawler children, not including Mirmelli's charge for the surgery.

The Lawlers have high praise for Mirmelli, and said they know the operations were necessary because during an office visit in February "he let us look down their throats and showed us how swollen they were."

They said this was the first time Mirmelli diagnosed tonsillitis in four of the children. An operation usually isn't called for until after repeated tonsillitis attacks.

Mirmelli did not schedule the operations, however, until after Lawler qualified for a public aid green card, the identification slip for families who qualify for medical services, Lawler said. "Finally it came . . . then I took the kids in, and he booked them," Lawler said.

"We didn't know Mirmelli accepted the green card, but he said it's the best insurance there is," Mrs. Lawler said.

So anxious is Mirmelli to perform tonsillectomies, *The Tribune* found, that one mother said he shouted that she didn't love her children if she didn't have their tonsils out.

Mrs. Canary Fipps, 36, of 2049 W. Warren Blvd., said she didn't want the tonsils of her six children removed because they had no problems with sore throats.

"He told her she didn't care nothing about her kids," her husband, Levi, recalled. "He said you all don't care nothing about your children if you don't have their tonsils out."

But, Mrs. Fipps said, "They didn't have any sore throats. All they had was a light cold sometimes. I just can't believe that all five of them had to have their tonsils out at the same time. They can't all be bad.

Mirmelli scheduled them for tonsillectomies at von Solbrig without Mrs. Fipps' permission, she said. She ordered him to cancel the operations, which were stricken from the surgical book at the last minute.

"He's just trying to get money," Fipps said. "That's the way it looks to me."

Mirmelli told *The Tribune* that every tonsillectomy he does is necessary, and that he does whole families in one session because "the children pass the infection. They live in very small quarters. They use the same glasses and utensils."

"That's nonsense," said Raffensperger of Children's Hospital, echoing other medical authorities who told *The Tribune* that tonsillitis is not passed in that manner. "I can't see what difference that would make."

Mirmelli presented reporters with pathologists' reports on removed tissue from 30 cases to back up his contention that the surgery was required. But medical authorities and pathologists contacted by *The Tribune*, including Mermelli's own pathologist, said such examinations would not determine whether the operation was necessary.

Mirmelli's three circumcisions on the Adam children were not unusual for von Solbrig Hospital, where circumcisions are performed routinely on youngsters, often in conjunction with other surgery.

One mother, Minnie Staten, 26, of 3709 W. Grenshaw St., told a *Tribune* reporter that after she asked Mirmelli to give her three boys circumcisions, he abruptly announced that they needed tonsils out, too, even though he had never before mentioned a tonsil problem.

Mrs. Staten said Mirmelli scheduled her children for tonsillectomies without her permission and she had the surgery cancelled at the last minute, allowing him to do only the circumcisions.

Only one of the three boys developed any complications, she said. But they all stayed in von Solbrig for three days, twice as long as usual for cases without complications, according to doctors. The hospital bill was $802, not including Mirmelli's charge for surgery.

Most specialists in the field discourage circumcisions that are not performed at birth unless infection of the foreskin is a chronic problem. Children should not be subjected to anesthetics and the trauma of surgery unless it is essential, doctors say.

"We have an ironclad policy," said Dr. Hugh Firor, head of pediatric surgery at Cook County Hospital. "We won't do a circumcision unless it is absolutely necessary." He and other physicians emphasized that a mother's request is not enough.

"It's like a mother coming in and saying she wants her kid's right ear taken off," Raffensperger of Children's Memorial said. "They might as well do that, too. There's no reason to do a circumcision."

The Tribune also found that when public aid children are brought into von Solbrig for tonsillectomies and circumcisions they are automatically given $14 worth of X-rays and the EKG.

The State is not billed directly for the X-rays and the EKG, but the charges figure in the formula the State uses to compute the hospital's flat daily fee for public aid patients.

An EKG on a youngster with no history of heart problems "serves no purpose," Firor said. "It doesn't tell you anything. It doesn't hurt the kiddie but it makes a fee for those doing it."

He estimated that EKG's were ordered on fewer than 50 of the 750 to 900 major and minor surgical procedures performed on children at Cook County Hospital last year.

Dr. Dean Leyers, a staff physician at von Solbrig, said he did not order the tests for two children he circumcised and that it was not necessary. However, he said, "the hospital seems to give them to all patients."

Mirmelli defended his use of the costly tests, saying he orders them for "the safety of the children." He also said he gives a chest X-ray to every child he admits to von Solbrig to check for incipient turberculosis.

The hospital charges $13 for services in its recovery room, a small room adjacent to surgery where postoperative patients are supposed to stay until a physician is satisfied that no immediate complications will develop from the surgery or the anesthetic.

In most hospitals the recovery room has its own staff and is regarded as vital to the success of the operation. At von Solbrig, however, it is just a stopping-off place on the way from surgery.

No doctor discharges patients from it, no registered nurse is on constant duty in it, there is no nursing station for it, *The Tribune* found. Yet all are required under Illinois regulations.

When asked to answer questions about hospital operations uncovered by *The Tribune* investigation, Dr. von Solbrig cut short the interview saying, "That's not your business."

VON SOLBRIG HAS CONTROL

Von Solbrig hospital is a for-profit corporation owned solely by Dr. Charles R. von Solbrig. The only officers listed for the corporation are Dr. von Solbrig and his wife, Dorothy.

The 83-bed hospital at 6500 S. Pulaski Rd. was built by von Solbrig in 1959.

He now holds the titles of president, medical director, administrator, and chief surgeon. Dorothy von Solbrig is listed as secretary of the corporation.

A separate corporation, that lists von Solbrig as president and Marilyn Monroe, a hospital employe, as secretary, holds a mortgage on the hospital.

Von Solbrig, 68, was graduated in 1933 from Chicago Medical School and was licensed that year as a general surgeon.

[From the Chicago Tribune, Sept. 9, 1975]

HOSPITAL HUNTS PATIENTS—GETS WELFARE CASH

TASK FORCE REPORT

A diffuse network of flophouse operators, ambulance companies, and a "patient recruiter" help keep the beds filled with public aid patients at Northeast Community Hospital, the city's largest private alcoholic treatment center. In this, the third of a series, Tribune Task Force Director Pamela Zekman and reporters Jay Branegan, William Crawford, and William Gaines take a look at the patient recruiting system.

An employe of Northeast Community Hospital regularly patrols Near North Side streets in a red truck or hospital van recruiting patients among the derelicts possessing public welfare cards, with promises of food and rest.

Desk clerks at seedy flophouses in the Near North and Uptown areas daily send residents to the hospital at 6970 N. Clark St., the largest private alcoholic treatment center in the city.

A Northeast Community physician holds regular office hours once a week in a flophouse that supplies the hospital with more patients than any other single source.

From all over the city, private ambulance companies take public aid recipients, easily able to use other transportation on expensive rides to Northeast, a violation of public aid regulations. In some cases, ambulances carrying "emergency" cases bypass other hospitals to go to Northeast, another public aid violation.

A *Tribune* task force investigation found that this is the way Northeast Community gets most of the 300 patients that its alcoholic treatment unit serves every month in a revolving-door process. The hospital, for these and other patients, last year received more than $2 million in welfare funds. It is guaranteed $78 a day for each public aid patient.

The passport into Northeast's patient-supply network is the medicaid green card, which pays for hospitalization, drugs, and the costly ambulance rides to and from the hospital. The green card, issued by the State Department of Public Aid, identifies a person as eligible for State-paid medical care.

Reporter William Crawford temporarily obtained a green card and found it gave him quick access to the system.

Almost as soon as he registered at a North La Salle Street hotel, the clerk made a reservation in Crawford's name for the following morning at Northeast's alcoholic treatment center.

But, he soon learned, there is an even easier way to get into the center—if a person has that all-important green card.

Alcoholics in the area explained they don't have to wait for a desk clerk to send them to Northeast. They can just watch for James Zimmerman, an alcoholic "intake counselor" employed at the hospital, to come around in his van.

One resident of the St. Regis Hotel, 516 N. Clark St., recalled that Zimmerman drove by recently, shouting to him, "Hey, you want to go on up to Northeast and see the doctor?"

Henry Rohland, the desk clerk at the La Salle Plaza Hotel, 873 N. La Salle St., who arranged for Crawford's admittance, also knows of Zimmerman.

"He makes the whole circuit in his truck," Rohland said. "Zimmerman comes around all the time and cons all these characters on the streets. They come here, and he carts them off in his red truck. On weekends he uses the hospital van to haul guys away in."

Though alcoholics, ambulance drivers, and hospital employes are familiar with Zimmerman's roundups, hospital official expressed shock at his alleged activities.

"We have never heard anything about his picking up patients off the street and bringing them to the hospital," said Richard Troy, a hospital director, Chicago Park District general counsel, and the attorney who represented Mayor Daley's delegation in its seating battle at the 1972 Democratic National Convention.

Only 4 months before Troy and other hospital officials were interviewed, Zimmerman testified about his activities in a Federal hearing on a labor dispute with the hospital.

He claimed to have an office in the La Salle Plaza Hotel paid for by the hospital and said, "I bring patients, or the potential patients, or out-patients, or whatever the alcholic person is to the hospital." Rohland denied that Zimmerman had an office in the hotel.

Another activity that hospital administrators claim they are uninformed about concerns the Northmere Hotel, 4943 N. Kenmore Ave., one of the hospital's prime sources of patients. The hospital recorded more than 100 patient admissions from the hotel in one 6-month period, according to public aid records.

A Northeast staff physician, Dr. Dan Stockhammer, holds regular office hours once a week at Northmere, charging public aid $7 a patient for an office visit. Stockhammer, who collected more than $40,000 last year in public aid payments, described his work at the hotel as a "closed clinic" for Northmere residents only.

"It's just like if the Drake or the Palmer House hotel had a doctor only this is a lower social strata," he said. He sees several dozen patients on each visit and claims they are sent to the hospital of their choice when hospitalization is necessary.

But Charles Heilig, former Northeast Hospital Alcoholic Treatment program director, said he set up the programs at the Northmere as an "aftercare" service. He recalled that the hospital could "count on" three or four admissions from Northmere every Thursday evening following Stockhammer's visits. In fact, the hotel, populated mainly by residents on welfare, seems to operate much like a residential care home though it has no license from the Chicago Board of Health.

The hotel manager, Mary Ann Bilanzich, according to hotel residents, ambulance drivers, and hospital employes, keeps medicine behind the desk and doles it out daily to residents.

"Mary Ann gives me my pill each morning," said one resident.

"Mary Ann keeps our green cards behind the desk and our medicine," said another.

"Mary Ann keeps short medical reports on all of us so she knows what our problem is," said a third.

And Walter Ressetar, an ambulance driver who made frequent pickups at the hotel, said, "She had what you would describe as a medicine call. I've seen it many times."

Such handling of medications would be a violation of city and State regulations, according to a Board of Health spokesman.

Miss Bilanzich denied that she kept any medications for hotel residents.

On May 3, 1974, she pleaded guilty to Federal charges of forgery and possession of stolen welfare checks and was placed on probation for a year. Northmere residents claim that she still keeps their welfare money, doling it out in $2-a-day allotments.

And they say it is Miss Bilanzich who also decides when they should go to the hospital.

"There's no way in the world that I would go to that hospital without Mary Ann's okay. I been at the Northmere 7 years, but I never was in Northeast until I got to Northmere and met Mary Ann. I take an ambulance to the hospital and back," said James Leavell, 50, a frequent patient.

"They treat people good at the hospital," said Leavell. "I been there several times."

Ted Pry, an owner of Rescue Ambulance Service, 4707 N. Harding Ave., said his company stopped servicing the Northmere in April because Miss Bilanzich persistently called for ambulances when they weren't needed to take residents to Northeast Hospital.

"Anytime a person got drunk, it seemed like they'd call from the Northmere for an ambulance. A majority of them really didn't need an ambulance. They could have gotten there another way. We got so we had to tell them we were too busy doing emergency work."

Rodney Murphy, a driver for Rescue, said calls came in almost once a night from the Northmere, and he was told to take residents to Northeast Hospital 90 per cent of the time.

"They could walk to the ambulance and they didn't need us," he recalled. "I have taken people to hospital when I have been called and they only have a toothache. I pay taxes too, and I don't like it, but I have to do it."

Taxpayers are charged $45 plus $1.30 a mile for each ambulance ride.

Ambulance service to Northeast is not limited to North Side hotels.

"I call any ambulance that's available," said Wylie Russel, 37, a four-time visitor to Northeast, who lives at 4518 S. Indiana Ave., more than 14 miles from the hospital. "They take me to the hospital, and when I'm discharged, they take me home. As long as your green card is legitimate, you can go to that hospital as many times as you want. Why, I could call one right now and go there if they had an open bed."

Tribune reporters posted outside the emergency entrance observed a steady stream of private ambulances arriving not only to deliver sick patients, some of them on stretchers, but also to pick up apparently healthy patients for a ride back home.

Indeed, *Tribune* reporters interviewed dozens of Northeast's public aid patients who said they are routinely taken home in the comfort of a private ambulance even though public aid regulations state that to use an ambulance service a patient must be too sick to go by public transportation.

A surveillance team watching the small parking area at the emergency room door one day saw it become clogged with private ambulances. Two patients walked nimbly across the lot from the emergency door threading their way through the traffic jam to an Ambulance Service Corp. vehicle. The ambulance attendants dropped their passengers off at the Northmere Hotel.

Max Rabin, owner of Ambulance Service, 14 E. Jackson Blvd., said the hospital called his company to take the patients home, claiming one was still dizzy from a head laceration and noting only that the other was hospitalized for "alcoholic rehabilitation."

"We were just told by the hospital to take them back," said Rabin. "They were sending them back by ambulance. That must be the hospital's procedure."

Rabin billed the state $55 for each patient. A cab would have cost about $4 for both of them.

Reporter Crawford was picked up as an "emergency" case by La Salle Ambulance Service Corp., 2427 N. Clark St., at his hotel, the La Salle Plaza, and taken to Northeast, more than seven miles away. Public aid regulations require that in emergency cases the patient be taken to the nearest hospital.

Crawford passed Henrotin Hospital, only a few blocks from his hotel, as well as three other hospitals near Lake Shore Dr. Dozens of other hospitals are closer than Northeast.

The bill to public aid was $69. The ambulance company told public aid that Crawford suffered "acute abdominal pains, chest pains, and difficulty in breathing."

In fact, Crawford walked easily away from the hotel to the ambulance and sat for the entire ride talking with the attendant.

"What's wrong with you?" the attendant asked, poring over some forms.

"I'm an alcoholic," Crawford replied. The attendant frowned and stared at the form.

"What else is wrong with you?" he asked. Crawford repeated his answer.

The attendant turned to the driver, Charles Booher, vice president of the company, with a perplexed look, appealing for guidance.

"Uh, I also have slight stomach pains," Crawford volunteered, an answer that satisfied the attendant. Crawford never mentioned chest pains, the breathing problem, or the "acute" stomach pains that the company later reported to public aid.

"They had to say that in order to get paid from the State as an emergency ride," observed Patrick Kain, assistant deputy director of medical programs at the Illinois Department of Public Aid. "We wouldn't approve a payment on an emergency call if the patient just had 'slight stomach pains.'"

The free ride to the hospital was arranged by Rohland, the desk clerk to the La Salle Plaza, when Crawford checked in the night before. Crawford had told Rohland he might be interested in going to Northeast.

"Yeah, anytime you're feeling sick just let me know, and I'll call the hospital and make a reservation for you," Rohland replied. "You just give me that green card of yours, and I'll make the reservation right now. That way a nice clean bed will be waiting for you when you get up there.

He picked up the telephone and dialed the admitting office at Northeast.

"This is Hank from the La Salle Plaza. I would like to make a reservation for one Crawford, William, for 9:30 a.m. in the morning, green card number of 07 204 02 E93667. That's for tomorrow at 9:30 a.m. Thanks."

"Okay, Bill, you're all set," he said, placing the receiver down and putting the green card in a mailbox behind him.

"Tomorrow either you come down here to the lobby, or I or the ambulance men will come up and get you," he continued. "Just sleep as long as you want, and when they arrive, we'll knock on your door."

Rohland then offered him a bottle of cheap wine, "on the house."

The next day, as promised, the ambulance arrived, and Crawford was admitted to Northeast without a hitch and without even seeing a doctor though hospital officials deny that desk clerks can guarantee admissions.

"This hospial is not a hotel," June Reichert, a registered nurse who has handled admissions since January, said in an interview.

(Tomorrow: Inside Northeast Community Hospital.)

[From the Chicago Tribune, Sept. 10, 1975]

HOSPITAL PROVES A COSTLY HAVEN FOR ALCOHOLICS

TASK FORCE REPORT

Thousands of alcoholics every year, most of them on public aid, go through the alcoholism treatment center at Northeast Community Hospital, a haven for welfare loafers and often a waste of time for patients who seek help. Conditions inside the hospital are described in this last article in a series by

Task Force Director Pamela Zekman and reporters Jay Branegan, William Crawford, and Williams Gaines.

For the alcoholic desperate for a cure, the hospital is a sham, the treatment a cruel joke.

For the welfare loafer eager for a free ride, it is a $73-a-day hotel where a person can float for days on powerful tranquilizers.

And for the taxpayer, Northeast Community Hospital is an expensive charade that squanders valuable medicaid dollars.

More than $2 million in public money went to Northeast last year, the bulk of it for its alcoholic treatment unit at 6970 N. Clark St., which give an estimated 300 patients a month, most on welfare, its revolving door treatment.

"He sends us over to that hospital, keeps us there 5 days, and turns us loose," one of three men standing on an Uptown sidewalk said of one Northeast doctor. "Look at us. We're all back drinking again. They don't do no good. I've been there six times."

The hospital offers a regimen of mind-numbing drugs in place of counseling and treatment for alcoholics on public aid who are brought here from seedy flophouses throughout the city.

Task force reporters interviewed alcoholics who have been patients in the hospital and examined State public aid records to document how the alcoholic treatment program works.

Reporter William Crawford, posing as a skid row alcoholic, was admitted to Northeast as a patient for a 5-day detoxification program, even though there was nothing wrong with him.

The hospital billed the State Department of Public Aid $394 for his "treatment."

State records reveal that many of the same patients return month after month, running up huge bills each time. The hospital now gets $73 a day for each public aid patient.

Here is what the task force found during its investigation of the 92-bed hospital:

Heavy doses of prescription tranquilizers and anti-convulsants are administered without a physician's examination. Crawford had his first dose three hours before he was seen by a doctor. Later, the physician offered him a choice of powerful drugs. The practice was described by one Chicago Board of Health consultant as a "miscarriage of medical practice."

Because of the hospital's lax admission standards, Crawford was admitted on the say-so of a hotel desk clerk without ever seeing a doctor, a practice that violates state public aid regulations.

The hospital is hot, filthy, and infested with cockroaches. Showers don't work and sanitary techniques are so lax that Crawford was fed a pill that had dropped to the floor and was given stained bed clothes and dirty eating utensils.

The staff was so indifferent to the welfare of the patients that nurses refused to attend two patients in isolation with open sores, and a patient had to mop his own room when water mixed with human waste overflowed from a toilet.

The man behind Northeast Community Hospital is Dr. Harold Dubner, a Winnetka psychiatrist who lists himself as vice president of the not-for-profit Charity Hospital Association, which officially operates both the Clark Street hospital and one at 6130 N. Sheridan Rd.. also called Northeast Community.

At $80,000 a year, he is the highest-paid hospital official and officer of the association. He is also medical director and got more than $37,000 last year in public aid payments.

One of the directors of the hospital is Richard J. Troy, general counsel of the Chicago Park District. He defended the alcoholic treatment program as "filling a great community need."

In 1968 the Sheridan Road hospital was closed by the city for 10 days when it was disclosed that two emergency cases were turned away and an unlicensed physician was on the staff. In a cosmetic shakeup the old Sheridan General name was changed and Dubner was shifted from director of admissions at Sheridan Road to the Clark Street facility.

The alcoholic treatment program has earned a reputation among public aid recipients throughout the city as a place where "you can get anything if you got that green card," the green medical eligibility card issued to welfare recipients for medical services and drugs. It guarantees Northeast $78 a day for each patient.

Some green card holders are skilled in the art of exploiting the welfare system.

"When I get out of here, I'm going home, cash my aid check and give the money to my old lady," one Northeast patient said upon his return to the hospital three days after he had been discharged. "Then I think I'll go to another hospital and spend a couple of weeks there."

His stay at Northeast cost the taxpayers $472.80.

Northeast's lax admission policies encourage such freeloaders. Consider Crawford's entry into the hospital:

He arrived in a private ambulance that had been summoned by the desk clerk at his flophouse hotel. After a comfortable ride sitting up chatting with the attendant, he hopped out and walked through the emergency room area.

Without talking to a doctor, nurse, or other medical personnel, he walked with the ambulance attendant to the switchboard in front of the hospital to drop off his green card. The switchboard operator told Crawford his room number, and Crawford climbed the stairs with the attendant to the second floor. There the attendant escorted Crawford to his room and bade him farewell.

Crawford was now a patient at Northeast Community Hospital.

Though he was chipper and alert and complained only of a slight stomachache, the hospital records show Crawford as a "patient admitted because of nausea, vomiting, [and] epigastric pain . . . Extremities: tremulous." These are the symptoms of delirium tremens [D.T.s], or alcoholic withdrawal.

The tentative diagnosis was "gastritis and duodenitis," the first an inflammation of the stomach lining, the second an intestinal disorder.

Both ailments are commonly associated with chronic alcoholism and are the most frequently listed admitting diagnosis on Northeast's public aid records.

Crawford's admitting diagnosis was made by his "attending physician" Dr. Mehmet Alpaslan, a Northeast staff physician who, according to his time card, was punched in and working at his $19-a-hour job at the Chicago Board of Health Uptown Clinic, 846 W. Wilson Ave., when Crawford was being admitted to Northeast.

Crawford saw no hospital medical personnel until after he was admitted and in his bed, when a nurses' aide came by to fill out forms.

"The patient should not be admitted until he has been examined by a doctor," said Patrick Kain, assistant deputy director of the Illinois Department of Public Aid medical programs division. "You don't just walk into a hospital and get a bed."

Alpaslan was notified by telephone of Crawford's admission, records show, and from his desk at the Uptown Clinic he placed the new patient on an intense program of vitamins, tranquilizers—including Librium and Dalmane—and Diltan, an anti-convulsant often used to control epileptic seizures, according to doctors.

Crawford was immediately given 100 milligrams of Diltan and 25 milligrams of Librium, 3 hours before Alpaslan saw him.

"It is totally inappropriate for a physician to order these drugs for someone he has not seen," according to Dr. Michael Werckle, associate director for health care facilities for the Illinois Department of Public Health.

"Only in an emergency should a physician order drugs over the phone for a patient he hasn't seen. And then they would be only mild drugs."

But Crawford's drugs were not mild, he said. "These drugs may be normal for a person going through D.T.s but not for a normal person."

A physician with the Chicago Alcoholic Treatment Center said the drug order should never have been made by phone and the dosages were "like using a cannon to shoot a sparrow." Crawford found the daytime medication made him groggy, and the sleeping pills at night put him to sleep almost instantly.

Alpaslan has refused to be interviewed, but hospital officials denied Crawford's drug dosage was excessive, automatic, or improperly dispensed.

"It is customary for a doctor to order a phone prescription based on the admitting diagnosis of a registered nurse," Dr. Dubner said. But Crawford never saw a registered nurse until he was handed his first pills at 2 p.m.

Alpasian finally examined his patient at 6 p.m., 5 hours after Crawford arrived at the hospital. Following a perfunctory 3-minute examination, he ordered a series of routine tests and continued his healthy patient on a steady diet of drugs, including the Dilantin for his nonexistent tremulousness."

Then he offered Crawford a choice of drugs. "You ask the nurse for whatever you need before bedtime, a nerve shot, a pain shot, or a sleeping pill," Alpaslan said.

Dr. Robert Lane, a Board of Health consultant, called the action, "a miscarriage of medical practice," explaining that most patients do not know the effects of drugs or their own medical needs.

Alpaslan visited Crawford each evening for a minute or two, talked brusquely and occasionally poked him. That was the extent of his examination. He routinely charges public aid $10 for each hospital visit.

The final diagnosis by Alpaslan was "acute alcoholic gastritis," and on public aid records the discharge diagnosis was "alcoholic addiction." Hospital records show Crawford was "advised" by Alpaslan "to go to the nearest health center or make an appointment in 2 weeks' time."

But Crawford got no such advice and no attempt was made to followup his case when he left. The doctor told him he could go at the end of 5 days, the maximum time public aid will pay for detoxifying alcoholics, and another man was assigned to his bed before Crawford even left his room.

Some of the drug dosages given Crawford were reduced after 3 days, but throughout his stay he never asked for any of the tranquilizers or displayed any of the physical symptoms requiring them.

An official with the alcoholic treatment program at Manteno Mental Health Center, Manteno, decride the use of heavy drugs in treating alcoholism. "It's a killer," he said. "You are merely substituting one addictive drug for another. An alcoholic can become easily addicted to tranquilizers."

And drugs were about the only "treatment" for the many patients who wanted to stop drinking.

"I was high the whole time I was there," Lilly Stewart, of 7240 S. Constance Ave., said in an interview. "I didn't know I was doing the same thing with drugs I was doing with alcohol, and now I'm hooked on drugs. I had two doses of pills before I saw the doctor."

During Crawford's 5-day stay he never saw an alcoholic treatment counselor, though the hospital employs about a dozen. He was never asked why he was drinking. He was never asked what sort of help or support he needed to kick his assumed dependence on alcohol.

Instead he was offered a daily hour-long "group therapy" lecture given by a reformed alcoholic. Only a few patients attended the optional sessions.

Besides a few Alcoholics Anonymous meetings, the only other planned activity during Crawford's stay was "occupational therapy," an hour-long exercise supervised by an untrained young woman in a small, ill-equipped room where patients fumbled about trying to make ceramic ashtrays and other bric-a-brac.

While Northeast's alcoholic treatment program is a sham, its facilities and staff for alcoholic patients are just as bad. The building is poorly maintained, many of the showers don't work, cleanliness is an afterthought, and the nurses and aides often ignore the needs of patients.

During Crawford's stay he killed 16 cockroaches in his room. He smashed one against the wall his first day there; its carcass remained for his entire stay.

When Crawford dropped a pill on the floor, a nurse picked it up and handed it back to him.

When he complained that he didn't have a fork to eat dinner, an aide simply took a used one from the plate of another patient, rinsed it and gave it to Crawford.

On some days the hospital ran out of fresh sheets, gowns, and pillow cases, and Crawford once was issued a soiled gown to replace the one he wore.

The patients with bona fide medical maladies got little attention from the nurses, who incessantly smoked around patients and spent much of their time in a patient's room watching TV soap operas. "The nurses were all foreign and didn't understand you," complained one former patient.

"I never go in there unless I have to," a nurses' aide once said to Crawford, pointing to the room of a man in isolation with festering sores on his legs. "I'm not going to catch that stuff."

A fellow patient was the only one who gave the man water, coffee, and cigarettes, performing the work of an orderly because no one else cared to.

One night, a toilet overflowed in a room with four patients, spreading water mixed with human waste across the floor. The stench filled the room and began to seep into the hallway, but no hospital personnel came to assist. One of the men had to mop it up himself.

An hour later, the toilet overflowed again. An old man, equipped with a walker, shuffled aimlessly through the stinking pool, but no hospital staff member was around to stop him. The mess remained on the floor for an hour before a janitor cleaned it up.

Said Michael Creed, 41, a three-time patient at the hospital:

"They treated everyone like animals."

Von Solbrig Hospital Placed on Probation

(By Pamela Zekman and William Gaines)

Dr. Eric Oldberg, president of the Chicago Board of Health, Tuesday placed von Solbrig Memorial Hospital on 1-month probation, during which the board will examine hospital records, interview employes, and conduct frequent inspections of the hospital's facilities.

Oldberg ordered the continuing investigation into the hospital after an informal hearing in the Civic Center during which he declared angrily, "We are not going to allow a fly-by-night institution that we license to run anywhere in the city."

At a separate press conference Tuesday, Governor Walker announced that he has asked the appropriate state department heads to investigate charges against the hospital.

Oldberg's anger was sparked when the hospital's owner and director, Dr. Charles R. von Solbrig, admitted that no State-certified medical specialists sit on the important Utilization Review Committee which is responsible for monitoring a hospital's patient care.

In fact, von Solbrig produced records showing, there are only two physicians on the committee, plus a registered nurse and von Solbrig's wife, Dorothy.

"That is absolutely unacceptable to the Chicago Board of Health," Oldberg shouted. ". . . You have a committee of no stature. You can't run a hospital like this."

He ordered von Solbrig to "recruit" board-certified specialists in surgery, obstetrics, internal medicine, pediatrics, and gynecology within the next month. "The doctors have to be recruited from outside the present staff," Oldberg said.

The Tribune task force has disclosed that unnecessary tonsillectomies and other operations are performed at the hospital, at 6500 S. Pulaski Rd. The stories also documented questionable medical practices and understaffing that is in violation of Board of Health regulations.

Oldberg said the *Tribune's* charges will be thoroughly investigated during the probationary period and warned that if the hospital does not meet board standards with regard to cleanliness and staffing as well as with regard to the medical review committee, "the consequences will be pretty severe."

Oldberg said he was "amazed" that von Solbrig, as sole owner, administrator, and medical director, did not know:

The names of the doctors on the utilization review committee, and whether they were certified specialists.

The names of seven of what he said were eight doctors who are assigned full-time emergency room duty. *The Tribune* disclosed that there are times when no doctor is assigned specifically to the emergency room, a violation of city codes.

Oldberg also said, "I'm amazed and chagrined that any hospital would have a review of its records and procedures [only] every 3 months," referring to the utilization review committee.

Also at the hearing was Dr. Edward J. Mirmelli, a long time associate of von Solbrig who, *The Tribune* disclosed, often performs assembly line tonsillectomies on entire welfare families in one day, although experts say the odds are astronomical that such surgery on even one family is required.

Mirmelli sat silently next to von Solbrig and von Solbrig's attorney Irwin Jann throughout the proceeding.

Dr. Murray Brown, commissioner of the Chicago Board of Health, said prior to the hearing that the Board of Health has no jurisdiction to review a doctor's patient treatments and could not stand in judgment of Mirmelli's or von Solbrig's medical competence.

"They have licenses from the State of Illinois and the State of Illinois has to do something about that," Brown said. Ronald Stackler, director of The Department of Registration and Education, announced Monday that the department is investigating both physicians for possible action before the medical licensing committee.

Oldberg also said that Board of Health doctors and nurses will check the hospital's surgical records, staffing, payroll records, and medical practices.

Thomas Cooney, executive administrator of hospital practices for the board of health, will head the investigation. Cooney said he is especially interested in emergency room staffing, a bogus list of staff doctors posted in the hospital lobby, and unauthorized personnel in the surgical area.

A *Tribune* reporter, working as a janitor in the hospital, frequently was called into the operating and recovery rooms to assist with patients, the stories disclosed.

"A Nice Place To Go," Doctor Tells Drunks

(By William Crawford Jr.)

One of Northeast Community Hospital's most frequent patients is Michael Wadley, a resident of the Northmere Hotel, 4943 N. Kenmore Ave., who was admitted to the hospital six times between October and May, according to State public aid records.

"I been in there eight or nine times in the past year and a half for my drinking problem," boasted Wadley, a pixie-faced man who looks half his 36 years. "Everyone in that hotel has been there at one time or another."

From October to May, Wadley spent 47 days in the hospital at the cost to the State Department of Public Aid of $3,827.

"They treat me okay at the hospital. I got no complaints," he said in an interview with a *Tribune* reporter.

Records show that on his four most recent visits to Northeast at 6970 N. Clark St., Wadley's physician was Dr. Dan Stockhammer, who holds weekly office hours at the Northmere.

"Dr. Stockhammer suggested it would be a nice place to go," he said. "Sometimes I call an ambulance; sometimes my friends call an ambulance. But mostly Mary Ann [Bilanzich, the hotel manager] calls an ambulance for me."

"When I'm drunk and feeling no pain, I don't want to go back," he explained. "But when I'm sober and really feeling the pain, then I go. When you're really sick, you want to go to the hospital. It does me good to dry out now and then; it gets me back on my feet."

Some of Wadley's bills list a charge for "occupational therapy" while he's confied to the hospital. This is part of the counseling and therapy program the hospital claims to run for its patients.

"That Alcoholics Anonymous [at Northeast] doesn't do no good," Wadley said. "That stuff goes in one ear and out the other. I went to one A.A. meeting, and I couldn't wait to get out and get me another drink."

[From the Chicago Tribune, Sept. 10, 1975]

Senate To Hold Hearings on Aid Fraud at Hospitals

(By Pamela Zekman and William Crawford Jr.)

Two United States Senators announced Saturday that hearings will be held in Washington into allegations of welfare abuses by two Chicago hospitals which were the subject of a *Tribune* task force investigation.

The announcement was made jointly by Senator Frank Moss [D., Utah], chairman of the Subcommittee on Long-Term Care of the Senate Committee on Aging, and Senator Percy [R., Ill.], ranking subcommittee member.

The Senators said the hearings are being called in response to the *Tribune* series and would be expanded to charges of medicaid fraud in hospitals, pharmacies, and nursing homes in other cities.

"The disclosures of wholesale surgery on welfare patients and of fraudulent claims being submitted for payment are shocking indeed," the Senators said in their joint statement.

The Senators called the investigation of von Solbrig Memorial Hospital, 6500 S. Pulaski Rd., and Northeast Community Hospital, 6970 N. Clark St., a "valuable public service."

"We shall ask *The Tribune* to cooperate with the committee staff in a wider examination into these and other reprehensible practices which affect the poor and the elderly," they said.

Some of the other practices include kickbacks between nursing homes and pharmacies and between hospitals and ambulance companies, and the policy of "dumping" State mental patients into nursing home unequipped to handle them, a committee staff member said.

Val Halamandaris, a staff member, said *The Tribune* investigation underscored committee research now in progress which shows there are "absolutely no controls" on abuses of the medicaid program.

"Medicaid is the easiest place to rip off if you want to rip off Uncle Sam," Halamandaris said. "There are no controls. The States are supposed to maintain the responsibility and the Federal Government is sitting back chewing its fingernails."

During several days of hearings to be scheduled in early October, the committee plans to hear testimony from scores of witnesses from Illinois in connection with *The Tribune* disclosures.

These will include former patients, staff, and operators of the two hospitals; ambulance drivers and ambulance company owners; physicians; and officials from local, State, and Federal public health and public aid agencies.

"We are interested in the fraud angle and in the question of bad medical practice," a staff member said.

Among the specific disclosures in *The Tribune* series which the committee will pursue are:

1. The assembly line tonsillectomies performed on entire families of public aid patients by Dr. Edward J. Mirmelli at von Solbrig Hospital. Medical authorities say the odds are astronomical that several members of the same family all would need the surgery at the same time.

2. The ordering of costly and apparently unnecessary tests at von Solbrig, such as chest X-rays on children hospitalized for such unrelated surgery as circumcisions and electrocardiograms on children even though specialists say they have no value unless a child has a history of heart trouble.

3. The apparently unnecessary hospitalization of patients for long stays at von Solbrig after they have been diagnosed by other physicians and hospitals as not in need of hospital treatment.

4. The network of hotels and Northeast Hospital employes who recruit and solicit medicaid card holders to fill the beds of the hospital's alcoholic treatment program.

5. The revolving door treatment of Northeast's alcoholic patients, which encourages welfare cheaters to return again and again, using the hospital like a $78-a-day hotel, and a place to get "high" on the battery of drugs automatically doled out to patients.

6. The ambulance companies that falsify records submitted to public aid to justify costly out-of-the-way emergency trips back and forth from Northeast at $45 and up for each trip.

During *The Tribune* investigation one task force reporter worked as a janitor at von Solbrig Hospital and another was admitted as a patient at Northeast. They documented flagrant violations of city and state health department regulations.

The Chicago Board of Health and the Illinois Departments of Registration and Education, Public Aid, and Public Health have begun investigations.

Appendix 3

STATEMENT AND ATTACHMENTS FROM THE ILLINOIS ASSOCIATION OF CLINICAL LABORATORIES, SUBMITTED BY EDMOND L. MORGAN*

Illinois Association of Clinical Laboratories
1600 W. Dempster St. Suite 106
Park Ridge, Illinois 60068

ILLINOIS ASSOCIATION OF CLINICAL LABORATORIES
2020 Parkside Dr. • Des Plaines, Illinois [illegible] • Tel: [illegible]

BEFORE THE UNITED STATES SENATE COMMITTEE ON AGEING
SEPTEMBER 26, 1975

JOINT HEARINGS OF SUB-COMMITTEES
ON LONG TERM CARE AND HEALTH OF THE ELDERLY

IN THE MATTER OF HEARING
OF THE QUALITY OF CARE OF MEDICAID
AND MEDICARE RECIPIENTS

PRESENTATION OF THE
ILLINOIS ASSOCIATION OF CLINICAL LABORATORIES
BY
EXECUTIVE SECRETARY, EDMOND L. MORGAN

1. Introduction and areas of abuse, overutilization
2. Medicare and Public Aid Payment Systems
3. Kickback problems
4. Professional Review Committee's
5. Logical Solutions
6. Conclusion
7. Resume of Executive Secretary
8. Enclosed Exhibits

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*See Statement, p. 79.

The Illinois Association of Clinical Laboratories, as the professional representative society of the Non-Physician Bioanalyst Laboratory Director in Illinois, is pleased to contribute its views on the matters of concern before the Sub-Committee on Ageing; we share in these concerns. Our members are distressed about a phase of the overall problem, practices of many "unethical" laboratory facilities which tend to question the integrity of all clinical laboratories in Illinois; and we, too, seek an elimination of these practices.

The Illinois Association of Clinical Laboratories was formed in 1947, well befor enactment of licensing statutes by Illinois and the federal government. Our goal then and now has been to maintain and foster ethical standards of professional conduct in the operation of clinical laboratories and the improvement of laboratory technique for the betterment of public health.

The Illinois Association of Clinical Laboratories was an early advocate of proficiency testing and quality control. Our Association has a strong program of continuing education. Our members are committed to a regimen of ethical practices.

Illinois is not unique in its problems in the laboratory field. The experiences of other states, notably the State of New York, indicate that abuses can be universal, (see item #1). We would wish to focus on what IACL perceives to be some of the more flagrant of these, and to provide recommendations concerning remedies.

OVER - UTILIZATION

There are indications that the average laboratory bill submitted to the Illinois Department of Public Aid by a poverty area facility covering green card testing often greatly exceed that of billings in other areas of Illinois. It is evident that "over-utilization" of testing services at some inner city facilities has become the rule rather than the exception. In many instances, business arrangements in these areas incorporating the joint efforts of the pharmacy, the laboratory, and clinic physicians, often under one roof, have as their genesis self help motives which encourage the proliferation of testing, as well as over dispensation of pharmaceuticals, cost savings to the state simply are not germane.

In reviewing bills submitted to the State and Medicare of those laboratories in which my office has received complaints of unethical activities it was quite evident that gross utilitization was occuring. Quite often the average bill was exceeding $75.00 per patient on a given day. In comparrison to bills submitted by ethical laboratories to the State and Medicare who are performing services in the same areas this pattern of overutilization was not evident. In dicussions with laboratory members at Reimbursement Committee hearings in Illinois, it was brought out that this particular reason of overutilization was a mechanism of kickbacks and compensation in the form of monies or other gimicks, such as, free employees to the physicians office, leased automobiles, rental of closets, payment of physicians supply bills or personal bills.

In our comparison with the number of tests ordered by certain physicians and clinics who themselves paid for limited laboratory testing out of their own pockets, no gross overutilization was evident. When these matters were brought up before authorities and public reimbursement agencies we were informed that little control could be exercised in this area since this was a matter for the medical society.

For the past five years our association has been quite active in attempting to police areas of abuse in the public aid and Medicare systems. Our frustrations in attempting to correct some of these unethical and unequitable schemes have led our association to form its own reimbursement and utilization review committee. Three times our association has been frustrated in our attempts to add ethical laboratory people to the medical advisory committee's of Public Aid and Medicare in Illinois.

Enclosed are examples in which specific instances have been brought to our attention involving the Chicago Medical Laboratory, Garco Medical Laboratory, Ridgeland Medical Laboratory, Aaron Cahan M.D. Laboratory, Tenn Clinical Laboratory, Western Medical Laboratory, Madison Medical Laboratory and D.J. Medical Laboratory (previously marked as Monticello Medical Laboratory).

The amount of volume in laboratory testing which you will note on these bills far exceeds what the average patient in 75% of physician's offices would receive as laboratory services for out-patient care.

You'll also note that many of these laboratories use factoring agencies in order to facilitate payment.

AREAS OF ABUSE

In 1974 myself and my administrative assistant along with two special investigators assigned to the Legislative Advisory Commission to the Illinois Department of Public-Aid inspected and investigated six laboratories chosen at random of whom we suspected of engaging in kickbacks and overutilization patterns in order to reap substantial sums of money.

1. Norvin Medical Laboratory, a very small laboratory was billing for numerous tests not performed in this facility. This laboratory was also billing for large sums of money without adequate facilities to perform these services.

2. D.J. Laboratory-Monticello Laboratory, also was billing for substantial sums of money without adequate facilities or personnel.

3. Chicago Medical Laboratory, same pattern existed in this facility and had no proper directors or supervisors.

4. Division Medical Laboratory, also heavily involved in gross utilization with suspected kickbacks to physicians clients.

5. Ridgeland Medical Laboratory, involved in gross utilization, suspected of kickbacks and had no verification records that these tests were even performed.

These are a few of the instances which we have actually investigated and have proven our suspitions were correct.

MEDICARE AND PUBLIC AID PAYMENT SYSTEMS IN ILLINOIS

Most of the Medicare and Medicaid patients for which laboratories perform services reside in nursing homes or convalescent and rest homes. The majority of laboratories have little difficulty in receiving reimbursement for services for which they are paid usually 80% under part B Medicare and for which the Illinois Department of Public-Aid is required to assume the responsibility of payment for the remaining 20%.

We have succeeded on many occasions in correcting inequities through negotiations and hearings. The difficulty arises with the department of Public-Aid in refusing to reimburse laboratories on the remaining 20 % with returned statements to the laboratory that Medicare has already reimbursed the laboratory more than they normally allow for 100% payment. It has been our experience that the Medicare receipients do not receive the same consideration as regular public assistance receipients. This is attributed to the political climate in Illinois in which one must have (clout) in Springfield in order to receive proper reimbursement. This requirement of (clout) is attributed to the interferrance of the so called factoring agencies into the internal affairs of the Illinois Department of Public-Aid. This requirement has not extended to the Medicate division and the factoring agencies usually will not handle Medicare payment vouchers.

FACTORING AGENCIES

It has recently come to our attention that certain criminal elements are involved in the purchase of laboratories and pharmacys and also involved in establishing factoring agencies. Our association estimates that approximately ten to twelve million dollars annually is being siphoned out of the Health Care dollar in Illinois through the padding of laboratory bills and overutilization. Of the six hundred million dollars annually spent in Illinois for health care through

Public-Aid for all services. It is estimated approximately one hundred to one hundred twenty five million is being siphoned out through some form of fraud and unethical billing practices.

It has been predicted that the Laboratory Industry which is now at approximately four billion dollars annually will have surpassed the drug pharmacutical industry in dollar volumn by 1978. Without the checks and balances in this professional field to correct fradulent billing schemes it is easy to observe why unscrupulous elements of society have infilitrated our profession. .Most State and Federal laws have no restriction upon the ownership of clinical laboratories. The restrictions are placed upon the director or technical personnel. The legitimate and ethical laboratory directors frankly are tired of this abuse and the use of the professional field by unethical non-professionals for fraudulent and unscrupulous money making schemes.

It has become a common view of our members that but for the participation of many of the so-called "factoring" or "billing" agencies, much of this over-utilization would be discovered and payments by Public -Aid reduced accordingly. The time delay between billing to and payment from Public-Aid, unfortunately, has enabled the presence of the "billing" agency. Such entities purchase Public Aid billings under a discount factor, normally 15%, and assist in "processing" the billing to ensure full payment. Many of these agencies purport to have a particular wisdom about the interplay between the contents of a Public-Aid Voucher and the reaction of Public-Aid computers to such vouchers, whether or not there is any validity to such suggestions is debatable; but the encouragement towards over-utilization is obviously implicit under such arrangements.

In practice, the billing agency becomes the customer of such facilities under an implied representation that the particular Public-Aid vouchers will be "made right" if necessary. When such facilities develop the belief that the integrity of their tests and their charges may be beyond review, there is an open invitation to abuse. If there is cheating on cost, quality must be equally suspect.

IACL believes that these abuses can be curtailed by the adoption of a bonding system, the use of a professional review committee to assist Public-Aid and Medicare in the review of billings, legislation, with criminal sanctions, and to require direct billing for laboratory services.

THE KICKBACK PROBLEM

Over-utilization and excessive billings are further encouraged by the practice of giving kickbacks to the referring physician. This is, of course, a violation of professional ethics upon the part of the physician as well as the facility. We join with the Illinois Medical Society in condemning the practice.

When the physician is barred from participating in laboratory fees, the stimulus for over-utilization and excessive billing with his concurrence is removed. This also returns the physician to his more traditional role of arbiter of both the quality and the cost of laboratory tests for his patients.

THE PROFESSIONAL REVIEW COMMITTEE

It is the contention of our association that the present systems utilized by the Department of Public-Aid apparently has been ineffective, the mechanism of screening abuse is inadequate and the processes of safeguarding installed by the department are well known to the billing or factoring agencies. Our association proposes that the departments of Public-Aid and Medicare have professional review committee's of all the provider service professionals instead of the present medical advisory boards.

Instead of the present medical advisory boards to assist these departments in their review of their laboratories and other provider bills.

For several years, Dr. Henry Holle, former Medical Director of Public-Aid had urged the formation of a laboratory peer review committee to assist the department in the screening of Public-Aid vouchers. Ethical laboratory owners are particularly' equipped to identify patterns of over-utilization and to properly provide advice to the department in this area. It would not be necessary for the review committee to know of the identity of a particular provider. Its function would be to screen vouchers on a periodic basis, to earmark abuses for consideration by the department when necessary. To support action taken on such recommendations, IACL urges the formation of such a review committee and offers to supply condidates for membership.

It is the contention of our Association that the present computerized review system now utilized by the Department of Public-Aid is ineffective, the mechanism of screening abuses is inadequate and the processes of safeguards installed by the Department are well known to the "billing" or "Factoring" agencies. Our Association would propose a different professional review system.

LOGICAL SOLUTIONS

One solution which was proposed in Illinois was the adaption of the bonding system. Under a bonding system, Public-Aid would retain a percentage from payments to facilities to be applied as an offset against subsequent disallowance of a part of the billing upon more thorough review. This would enable prompt payment of vouchers without jeopardizing the ability of Public Aid to balance the account from retentions where later indicated.

The percentage retention could be based on experience, by reviewing the history of each participating facility at periodic intervals as revealed by the integrity of billing practices. This would encourage correct billing with a correlary benefit in reduced percentage retention requirements for the ethical provider.

Conversely, maximum percentage retention would apply where indicated.

IACL favors the bonding system to re-affirm that the primary accountability for the integrity of its billings to Public Aid and Medicare must remain with the facility or provider. The bonding system would require the adoption of professional review committee's and a maximum dollar payout amount at any particular month based upon previous experience. Unfortunately in Illinois the factoring agencies have sued the department to stop the bonding systems.

Another solution which I have previously mentioned which has been in effect in Illinois for four years is a Laboratory Reimbursement and Utilization Review Committee which would consist of professional providers, specialists, reimbursement agencies and respected public members. As in Illinois this committee also contains a peer review committee which must report back to the general committee for dispositions of its decisions. Unfortunately this committee which we have started in Illinois has no legitimate authority.

Legislation which prohibits factoring agencies and the purchasing of Medicare and Public Aid bills.

Legislation to prohibit ownership of laboratories and other health facilities by other than professional health provider. This would eleminate the infiltration of lucrative professional fields by unscrupulous or criminal non-professionals.

CONCLUSION

It is the expectation of our Association that this Committee will seriously consider ou proposals and suggestions as outlined in my presentation in order that ethical providers in Illinois and other states are not penalized or discouraged from within he "system" and that these services are of the quality for which the public is entitled.

On behalf of the Illinois Association of Clinical Laboratories, I will be present at the Committee's meeting on September 26, 1975 to summarize aspects of these proposals and to respond to any questions. We are also prepared to provide specific information as required.

A summary of my background in the laboratory field is enclosed.

For Appearance Berfore: United States Senate Committee on Ageing
Committee September 26, 1975

Resume of Edmond L. Morgan, Bioanalyst
Executive Secretary, Illinois Association of Clinical Laboratories

Mr. Morgan is a Board Certified Bioanalyst Laboratory Director, certified by the American Board of Bioanalysts as a qualified professional laboratory director with twenty-six years experience in the clinical laboratory field.

He is licensed by the State of Illinois as Director of DeRidge Clinical Laboratory at 1600 West Dempster Street, Park Ridge, Illinois, a sole-owned proprietorship facility in operation for twelve years.

He is certified as a clinical laboratory director by the United States Department of Health, Education and Welfare as a provider of services under the Federal Medicare program.

Mr. Morgan is and has been Executive Secretary for eleven years in a non-salaried position of the Illinois Association of Clinical Laboratories, an Illinois not-for-profit professional State Society affiliate of the American Association of Bioanalysts, representing independent licensed laboratories and bioanalysts in Illinois.

He is currently National Director of Continuing Education and as such is a board member of this national professional society representing qualified non-physician laboratory directors in the United States and Canada.

He is immediate past President-Elect of the American Association of Bioanalysts.

He is Secretary for the Illinois Laboratory Reimbursement and Utilization Review Committee, a Committee of Professional Laboratorians, reimbursement agencies, specialists and member of the general public. This Committee also contains a representative of the Illinois Department of Public Aid.

By invitation, Mr. Morgan has attended the following conferences:

Attended the Secretary's of HEW's Regional Conferences on Health Care Costs in Cleveland, Ohio October 1968

Attended the 1st National Conference on Laboratory Proficiency Testing conducted by HEW in Atlanta 1971

Attended the 1st National Conference on Laboratory Continuing Education conducted by HEW in Atlanta May 1972

Attended the 1st National Conference on Medical Laboratory Diagnostic products conducted by the Dept. of HEW in Atlanta 1972

Attended the Region V of HEW Conferences on Health Occupations Education in Chicago 1972

He is a current member of:
Park Ridge Rotary Club
DesPlaines Elks Club
Chicago Society of Association Executives

Respectfully submitted,

Edmond L Morgan

Edmond L. Morgan

Executive Secretary, Illinois Association

of Clinical Laboratories

Chicago Tribune, Thursday, January 6, 1972

$1 Billion in Medicaid Wasted Thru Cheating, N.Y. Jury Finds

BY VINCENT BUTLER

[Chicago Tribune Press Service]

NEW YORK, Jan. 5—Almost $1 billion in Medicaid money went down the drain because of malpractice, cheating, and ministration of the program in New York City, a grand jury reported today.

Its report detailed abuses by doctors, dentists, podiatrists, pharmacies, physical therapists, and nursing homes. The report was made public by state Supreme Court Justice Jacob Grumet who called its revelations "scandalous and shocking."

Medicaid provides medical assistance for the poor. It can be established by state governments under enabling authorization by the federal government.

50 Pct. Federal Funds

In New York, Medicaid services are financed with 50 per cent federal financing and 25 per cent each by the state and local governments. It is administered here by the Department of Social Service and the Department of Health.

District Atty. Frank Hogan and the grand jury have been investigating the program for two years, covering the period from May 1, 1966, to Dec. 31, 19[illegible]. In that period $1,[illegible],421,597 of government funds was spent.

The grand jury's investigation is continuing. One dentist has been indicted but the district attorney's office refused to comment on the possibility of further indictments.

In releasing the report, Grumet said: "almost 50 per cent went down the drain. That means almost $1 billion."

$2 Million Lost

"One matter mentioned in the report is almost incredible," Grumet said. "The city lost $2 million because they failed to send in their request to the federal government for that amount in time." He said city officials had claimed they had not had the necessary data in time to make the claim.

In its report, the jury said that malpractice by some dentists jeopardized lives of patients. It told of a 7-year-old child who had been given anesthesia six times for the extraction of baby teeth that could have been removed with one dose of anesthesia. The extra doses netted the dentist $60.

The grand jury requested the court to send copies of its report to all top state and city officials. "It is evident," the jury said, "that improper and corrupt practices disclosed by this investigation were in large measure caused by the fact that the essential services were administered in a completely disorganized, if not chaotic manner."

It also made a series of recommendations designed to improve administration of the program and to minimize the "fraudulent practices" alleged in the report. It called on the city to institute lawsuits to recoup the money "obtained by Medicaid providers as a result of overutilization, unnecessary services, and fraudulent practices."

~~[illegible]~~ 4-16-73

INDEPENDENT LABORATORY
(Type or Print all Information)

APRIL 73

2. CASE LAST NAME | FIRST NAME
[redacted]

ADDRESS:

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
[redacted]

4. Case Identification Number
[redacted]

5. Office Account No.
30896

6. Birthdate

Leave Blank | 7. | 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
4/16	83420	THYROID PROTEIN-BOUND IODINE, PBI, BLOOD	$ 10.00
4/16	83440	THYROID TRI-IODO-THYRONINE, T-3	15.00
4/16	83465	THYROID INDEX, T-4 UPTAKE	15.00
4/16	81000	URINALYSIS ROUTINE, COMPLETE	3.00
4/16	84330	SUGAR GLUCOSE BLOOD (FASTING BLOOD SUGAR)	5.00
4/16	84520	UREA-NITROGEN BLOOD	5.00
4/16	82465	CHOLESTEROL BLOOD	6.00
4/16	84550	URIC-ACID BLOOD CHEMICAL	5.00
✓ 4/16	82575	CREATININE CLEARANCE	5.00
4/16	85015	BLOOD-COUNT COMPLETE AUTOMATED WITH INDICES	6.00

16. Name and Address of Independent Laboratory (Number and Street, City, State, Zip Code) Print, Type or Stamp

PMC--

DIVISION MEDICAL LAB
3525 W. PETERSON AVE.
CHICAGO, IL 60659

17. Provider Number:
14-3185

18. Name and Address of Referring Physician
JACINTO VILLA
2409 W NORTH
CHICAGO IL

13. TOTAL CHARGE	$
14. CREDIT	$
15. NET CHARGE	$ 75.00

19. DIAGNOSIS or CONDITION:
Obesity

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other *(Specify)*

21. *CERTIFICATION*

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX ~~of the~~ Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER

5/ 7/73
DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By. Date: MAY 15 1973

DPA 315 (R-11-71)

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of JULY, 19 73

CASE LAST NAME PROBANT	FIRST NAME SARAH
ADDRESS: 1509 N. California	

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: SARAH

5. Office Account No.:

4. Case Identification Number: 03 217 142377

6. Birthdate: 4 3 13

Leave Blank 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
7-30-73	84170	Protein serum total and albumin/globulin ratio	$ 14.—
"	84450	Transaminase blood glutamic oxalo-acetic, SGOT, ultraviolet method	8.—
"	84460	Transaminase blood glutamic pyruvic, SGPT, time ultraviolet	8.—
"	85650	Sedimentation rate, ESR	7.—
"	84330	Sugar, glucose, blood	7.—
"	84520	BUN - urea nitrogen, blood	7.—
"	83520	Icterus Index, blood	7.—
"	82250	Bilirubin Blood, total	7.—
"	87130	Culture urine definitive, + sensitivity study for specific	18.—
		micro-organism, with isolation of organism.	
"	85015	CBC, complete automated cell counts, hgb. Hct. + indices.	10.—

16. Name and Address of Independent Laboratory (Number and Street, City, State, Zip Code) Print, Type or Stamp

RIDGELAND MEDICAL LABORATORY
328 MADISON STREET
OAK PARK, ILLINOIS 60302
524-0403

17. Provider Number (Print, Type or Stamp): 14-8254

18. Name and Address of Referring Physician:
ANTONIO dela CRUZ, M.D.
2737 W. North Ave. Chgo.

13. TOTAL CHARGE	$ 93.00
14. CREDIT	$
15. NET CHARGE	$ 93.00

19. DIAGNOSIS or CONDITION:
Diabetes Mellitus Hypertension
non-specific skin rash
Jaundice - etiology (?)

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

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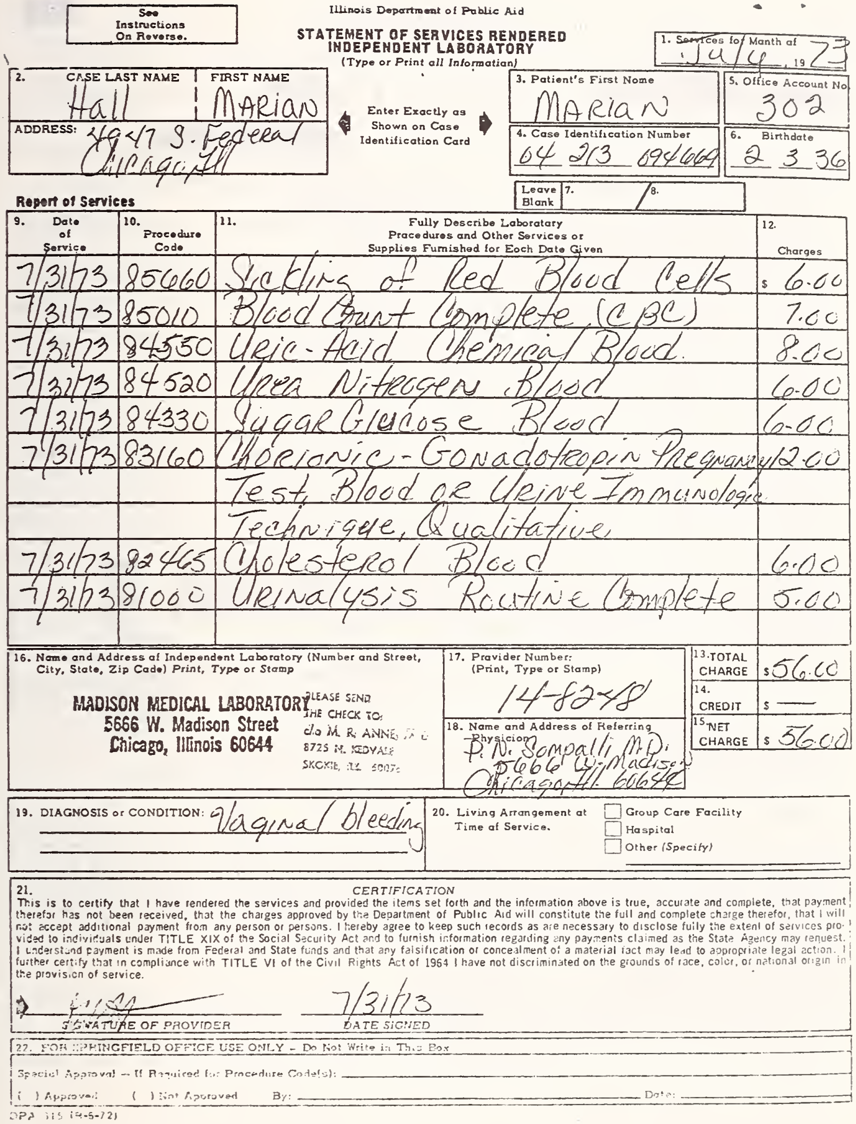
Villanueva — 9/27/73
SIGNATURE OF PROVIDER — DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date:

DPA 315 (8-11-71)



See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of July, 1973

2. CASE LAST NAME: Hall FIRST NAME: MARIAN

ADDRESS: 4947 S. Federal
Chicago, Ill

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: MARIAN

5. Office Account No: 302

4. Case Identification Number: 04 213 094669

6. Birthdate: 2 3 36

Leave Blank 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
7/31/73	85660	Sickling of Red Blood Cells	$ 6.00
7/31/73	85010	Blood Count Complete (CBC)	7.00
7/31/73	84550	Uric-Acid Chemical Blood.	8.00
7/31/73	84520	Urea Nitrogen Blood	6.00
7/31/73	84330	Sugar Glucose Blood	6.00
7/31/73	83160	Chorionic-Gonadotropin Pregnancy	12.00
		Test, Blood or Urine Immunologic	
		Technique, Qualitative	
7/31/73	82465	Cholesterol Blood	6.00
7/31/73	81000	Urinalysis Routine Complete	5.00

16. Name and Address of Independent Laboratory (Number and Street, City, State, Zip Code) Print, Type or Stamp

MADISON MEDICAL LABORATORY
5666 W. Madison Street
Chicago, Illinois 60644

PLEASE SEND
THE CHECK TO:
c/o M. R. ANNE, [illegible]
8725 N. KEDVALE
SKOKIE, ILL. 6007[illegible]

17. Provider Number: (Print, Type or Stamp) 14-8248

18. Name and Address of Referring Physician
P. N. Sompalli M.D.
5666 W. Madison
Chicago, Ill. 60644

13. TOTAL CHARGE $56.00

14. CREDIT $ —

15. NET CHARGE $ 56.00

19. DIAGNOSIS or CONDITION: Vaginal bleeding

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other *(Specify)*

21. *CERTIFICATION*

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER

7/31/73
DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date:

DPA 315 (R-5-72)

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of [redacted]
AUGUST 73

2. CASE LAST NAME | FIRST NAME
[redacted]
ADDRESS:

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
[redacted]

4. Case Identification Number
[redacted]

5. Office Account No.
A 7346

6. Birthdate

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
8/16	82385 ✓	CEPHALIN FLOCCULATION BLOOD	$ 6.00
~~8/16~~	~~82040~~	ALBUMIN/GLOBULIN RATIO BY ELECTROPHORETIC METHOD	~~11.00~~
8/16	84170 ~~84155~~	PROTEIN SERUM TOTAL, CHEMICAL	12.00 ~~6.00~~
8/16	84330	SUGAR GLUCOSE BLOOD (FASTING BLOOD SUGAR)	6.00
8/16	84520	UREA-NITROGEN BLOOD	6.00
8/16	81000	URINALYSIS ROUTINE, COMPLETE	4.00
8/16	93000 ✓	ELECTROCARDIOGRAM WITH INTERPRETATION & REPORT	17.00
8/16	82465	CHOLESTEROL BLOOD	7.00
8/16	84455	TRANSAMINASE BLOOD GLUTAMIC OXALO-ACETIC, SGOT	9.00
8/16	84465	TRANSAMINASE BLOOD GLUTAMIC PYRUVIC, SGPT	9.00
8/16	82470	CHOLESTEROL ESTERS BLOOD	9.50

OVERRIDE 2

16. Name and Address of Independent Laboratory (Number and Street, City, State, Zip Code) *Print, Type or Stamp*

CHICAGO MEDICAL LAB.
3525 W. PETERSON AVE.
CHICAGO, IL 60659

17. Provider Number:
14-8227

18. Name ~~and Address of Referring~~ Physician
DR. SARITA
2300 TAYLOR
CHICAGO IL

13. TOTAL CHARGE $

14. CREDIT $

15. NET CHARGE $ 90.50

19. DIAGNOSIS or CONDITION:
ALCOHOLISM

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other *(Specify)*

21. *CERTIFICATION*

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

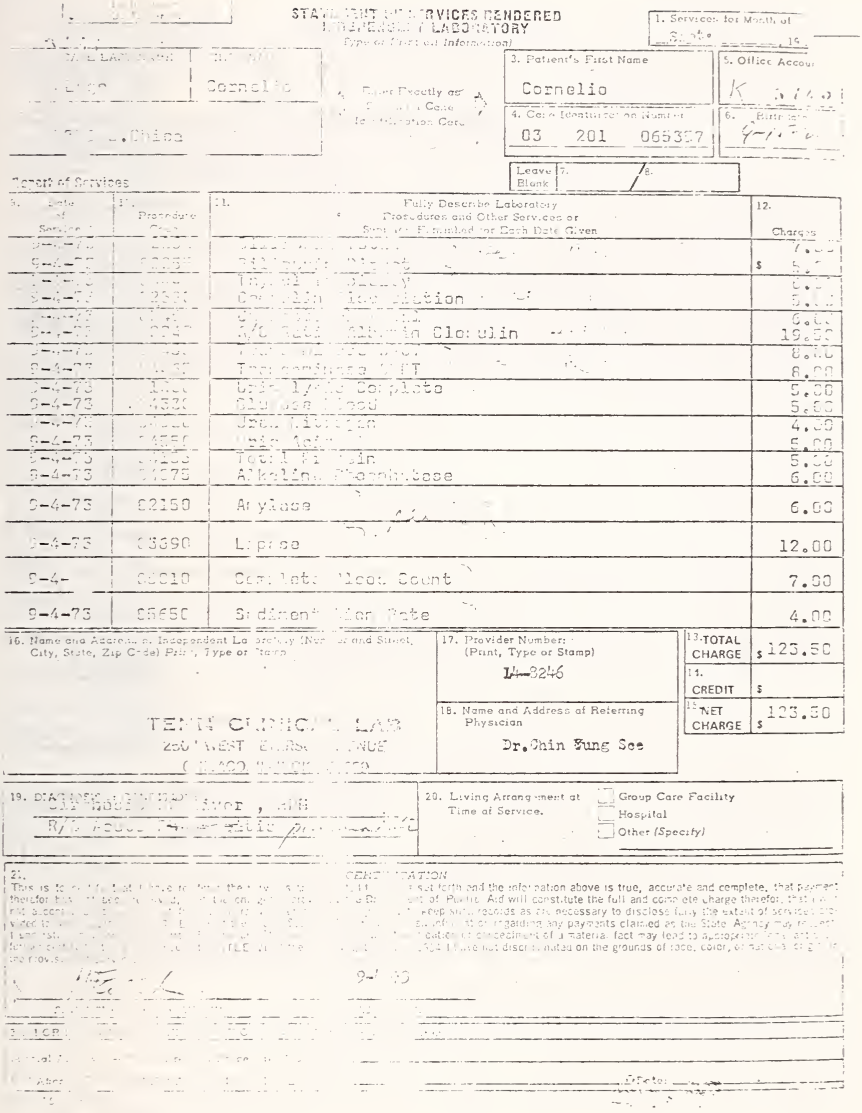
SIGNATURE OF PROVIDER

8/22/73
DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By Date:



STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of Sept. 19

[illegible] Cornelio

[illegible] .Chica[illegible]

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Cornelio

4. Case Identification Number: 03 201 065357

5. Office Accou[illegible]: K [illegible]

6. Birthdate: [illegible]

Leave Blank 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
[illegible]	[illegible]	[illegible]	7.[illegible]
9-4-73	[illegible]	Bil[illegible] Direct	$ 5.[illegible]
[illegible]	[illegible]	Thymol Turbidity	6.[illegible]
9-4-73	[illegible]	Cephalin Flocculation	5.[illegible]
[illegible]	[illegible]	[illegible]	6.00
9-4-73	[illegible]	A/G Ratio Albumin Globulin	19.50
[illegible]	[illegible]	[illegible]	8.00
9-4-73	[illegible]	Transaminase [illegible]	8.00
9-4-73	[illegible]	Urinalysis Complete	5.00
9-4-73	[illegible]	Glucose Blood	5.00
9-4-73	[illegible]	Urea Nitrogen	4.00
9-4-73	[illegible]	Uric Acid	5.00
9-4-73	[illegible]	Total Protein	5.00
9-4-73	[illegible]	Alkaline Phosphatase	6.00
9-4-73	82150	Amylase	6.00
9-4-73	83690	Lipase	12.00
9-4-	85010	Complete Blood Count	7.00
9-4-73	85650	Sedimentation Rate	4.00

16. Name and Address of Independent Laboratory (Number and Street, City, State, Zip Code) Print, Type or Stamp

TENTH CLINICAL LAB
250 WEST [illegible] AVENUE
CHICAGO, ILLINOIS [illegible]

17. Provider Number: (Print, Type or Stamp) 14-3246

18. Name and Address of Referring Physician: Dr. Chin Fung See

13. TOTAL CHARGE	$ 123.50
14. CREDIT	$
15. NET CHARGE	$ 123.50

19. DIAGNOSIS [illegible]: [illegible] Liver , [illegible]
R/O [illegible]itis

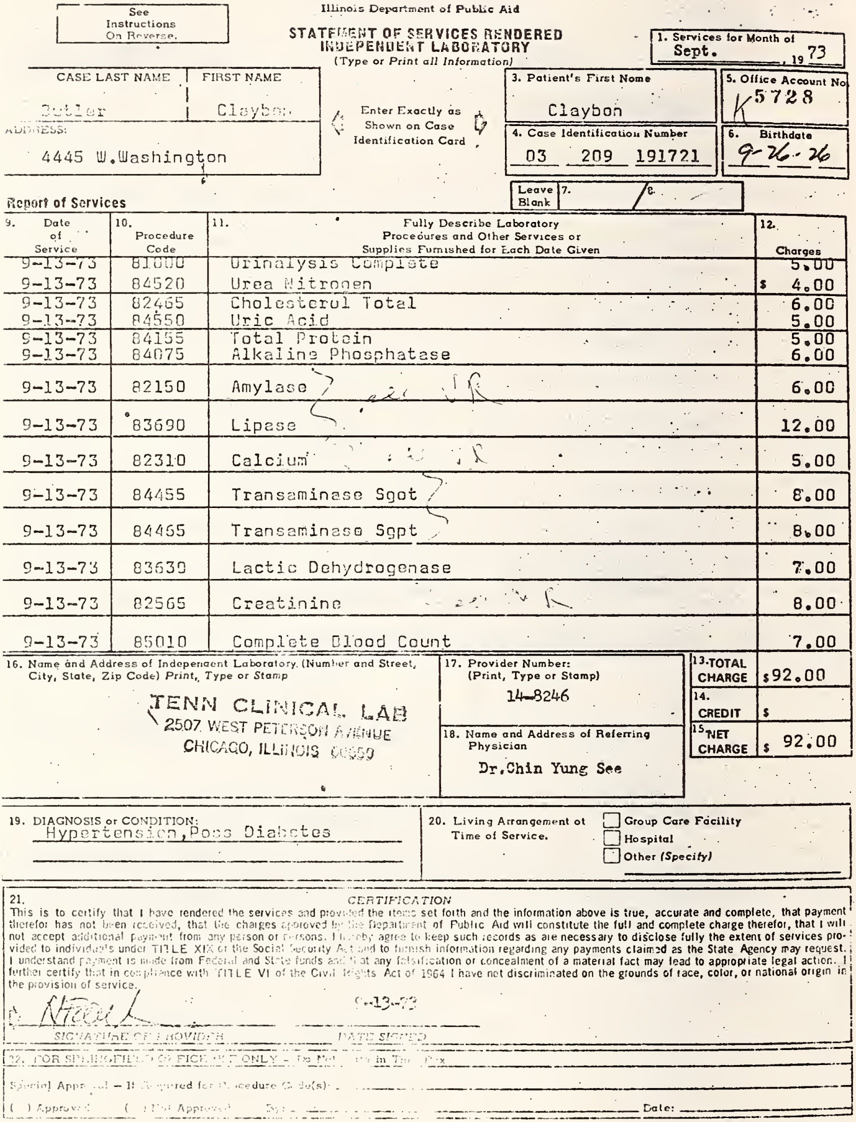
20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have [illegible] set forth and the information above is true, accurate and complete, that payment therefor [illegible] Department of Public Aid will constitute the full and complete charge therefor, [illegible] keep such records as are necessary to disclose fully the extent of services provided [illegible] information regarding any payments claimed as the State Agency may request. [illegible] falsification or concealment of a material fact may lead to appropriate [illegible] TLE [illegible] 1964 I have not discriminated on the grounds of race, color, or national origin [illegible] the provisions [illegible]

9-[illegible]-73

Date: [illegible]



See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of Sept., 1973

CASE LAST NAME	FIRST NAME
Butler	Claybon

ADDRESS: 4445 W.Washington

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Claybon
4. Case Identification Number: 03 209 191721
5. Office Account No: K 5728
6. Birthdate: 9-26-26

Leave Blank 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
9-13-73	81000	Urinalysis Complete	5.00
9-13-73	84520	Urea Nitrogen	$ 4.00
9-13-73	82465	Cholesterol Total	6.00
9-13-73	84550	Uric Acid	5.00
9-13-73	84155	Total Protein	5.00
9-13-73	84075	Alkaline Phosphatase	6.00
9-13-73	82150	Amylase	6.00
9-13-73	83690	Lipase	12.00
9-13-73	82310	Calcium	5.00
9-13-73	84455	Transaminase Sgot	8.00
9-13-73	84465	Transaminase Sgpt	8.00
9-13-73	83630	Lactic Dehydrogenase	7.00
9-13-73	82565	Creatinine	8.00
9-13-73	85010	Complete Blood Count	7.00

16. Name and Address of Independent Laboratory. (Number and Street, City, State, Zip Code) Print, Type or Stamp

TENN CLINICAL LAB
2507 WEST PETERSON AVENUE
CHICAGO, ILLINOIS 60659

17. Provider Number: (Print, Type or Stamp) 14-8246

18. Name and Address of Referring Physician: Dr.Chin Yung See

13. TOTAL CHARGE	$92.00
14. CREDIT	$
15. NET CHARGE	$ 92.00

19. DIAGNOSIS or CONDITION: Hypertension,Poss Diabetes

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

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SIGNATURE OF PROVIDER

9-13-73
DATE SIGNED

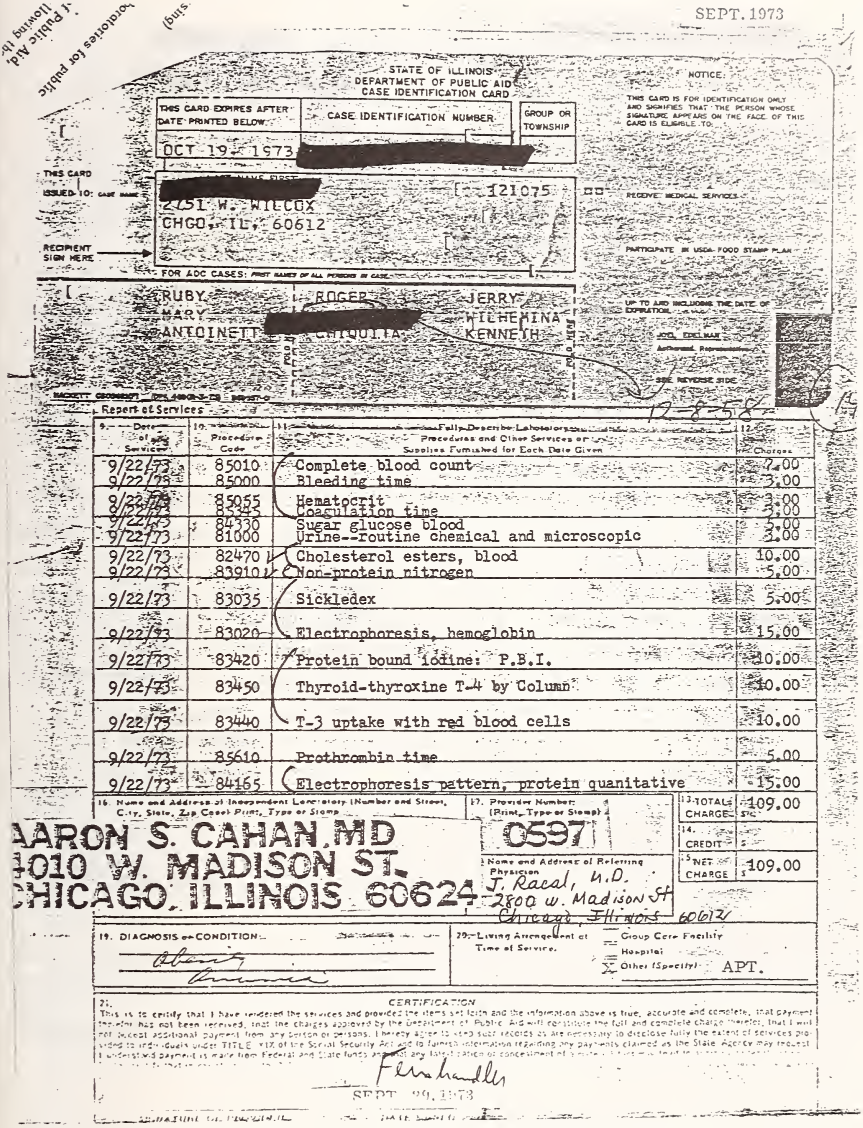
22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date:

DPA 315

NOV 8 1973



SEPT. 1973

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
CASE IDENTIFICATION CARD

THIS CARD EXPIRES AFTER DATE PRINTED BELOW	CASE IDENTIFICATION NUMBER	GROUP OR TOWNSHIP
OCT 19 1973	[redacted]	

THIS CARD ISSUED TO: CASE NAME

[redacted]
2751 W. WILCOX
CHGO, IL, 60612

121075

RECIPIENT SIGN HERE

FOR ADC CASES: FIRST NAMES OF ALL PERSONS IN CASE

RUBY	ROGER	JERRY
MARY	[redacted]	WILHEMINA
ANTOINETTE	CHIQUITA	KENNETH

NOTICE:

THIS CARD IS FOR IDENTIFICATION ONLY AND SIGNIFIES THAT THE PERSON WHOSE SIGNATURE APPEARS ON THE FACE OF THIS CARD IS ELIGIBLE TO:

RECEIVE MEDICAL SERVICES

PARTICIPATE IN USDA FOOD STAMP PLAN

UP TO AND INCLUDING THE DATE OF EXPIRATION.

JOEL EDELMAN
Authorized Representative

SEE REVERSE SIDE

12-8-58

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
9/22/73	85010	Complete blood count	7.00
9/22/73	85000	Bleeding time	3.00
9/22/73	85055	Hematocrit	3.00
9/22/73	85345	Coagulation time	3.00
9/22/73	84330	Sugar glucose blood	5.00
9/22/73	81000	Urine--routine chemical and microscopic	3.00
9/22/73	82470	Cholesterol esters, blood	10.00
9/22/73	83910	Non-protein nitrogen	5.00
9/22/73	83035	Sickledex	5.00
9/22/73	83020	Electrophoresis, hemoglobin	15.00
9/22/73	83420	Protein bound iodine: P.B.I.	10.00
9/22/73	83450	Thyroid-thyroxine T-4 by Column	10.00
9/22/73	83440	T-3 uptake with red blood cells	10.00
9/22/73	85610	Prothrombin time	5.00
9/22/73	84165	Electrophoresis pattern, protein quanitative	15.00

16. Name and Address of Independent Laboratory (Number and Street, City, State, Zip Code) Print, Type or Stamp

AARON S. CAHAN, MD
3010 W. MADISON ST.
CHICAGO, ILLINOIS 60624

17. Provider Number (Print, Type or Stamp)
0597

Name and Address of Referring Physician
J. Racal, M.D.
2800 W. Madison St
Chicago, Illinois 60612

13. TOTAL CHARGE	$109.00
14. CREDIT	$
15. NET CHARGE	$109.00

19. DIAGNOSIS or CONDITION:
Obesity
Anemia

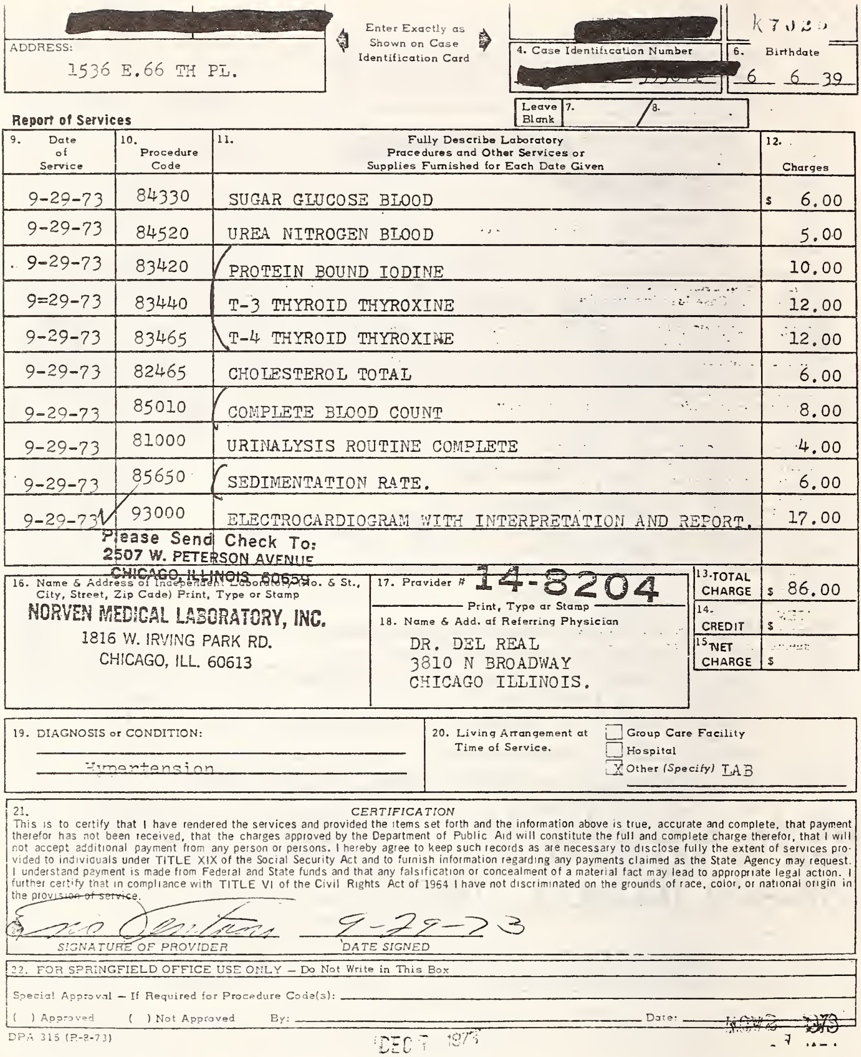
20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☒ Other (Specify) APT.

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to [illegible]

Fleishandler
SEPT. 20, 1973

SIGNATURE OF PROVIDER   DATE SIGNED



[redacted]

ADDRESS:
1536 E.66 TH PL.

Enter Exactly as Shown on Case Identification Card

[redacted]

K7020

4. Case Identification Number
[redacted]

6. Birthdate
6 6 39

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
9-29-73	84330	SUGAR GLUCOSE BLOOD	$ 6.00
9-29-73	84520	UREA NITROGEN BLOOD	5.00
9-29-73	83420	PROTEIN BOUND IODINE	10.00
9=29-73	83440	T-3 THYROID THYROXINE	12.00
9-29-73	83465	T-4 THYROID THYROXINE	12.00
9-29-73	82465	CHOLESTEROL TOTAL	6.00
9-29-73	85010	COMPLETE BLOOD COUNT	8.00
9-29-73	81000	URINALYSIS ROUTINE COMPLETE	4.00
9-29-73	85650	SEDIMENTATION RATE.	6.00
9-29-73 ✓	93000	ELECTROCARDIOGRAM WITH INTERPRETATION AND REPORT.	17.00

Please Send Check To:
2507 W. PETERSON AVENUE
CHICAGO, ILLINOIS 60659

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
NORVEN MEDICAL LABORATORY, INC.
1816 W. IRVING PARK RD.
CHICAGO, ILL. 60613

17. Provider # 14-8204
Print, Type or Stamp

18. Name & Add. of Referring Physician
DR. DEL REAL
3810 N BROADWAY
CHICAGO ILLINOIS.

13. TOTAL CHARGE	$ 86.00
14. CREDIT	$
15. NET CHARGE	$

19. DIAGNOSIS or CONDITION:
Hypertension

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☒ Other (Specify) LAB

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER

9-29-73
DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date: NOV 2 1973

DPA 315 (R-8-73)

DEC 7 1973

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of Dec, 19 74

2. CASE LAST NAME: Wynn
FIRST NAME: Christella

ADDRESS: 7936 S. Normal Chgo, Ill.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Zennett

4. Case Identification Number: 04-218-203570 X

5. Office Account No: [illegible]

6. Birthdate: 10-16-56

Leave Blank 7. 8.

1051

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
12-3-73	85015	CBC	$ 8.00
	81000	Urinalysis	5.00
	89370	Sma 12/60	25.00
	85660	Sickle Cell	5.00
	82955	G6PD	15.00
	83440	T, 3	10.00
	83455	T, 4	12.00
	83020	Hgb, Electrophoresis	25.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

GENERAL MEDICAL LABORATORIES, LTD.
SOUTH SIDE BANK
4659 COTTAGE GROVE AVE.
CHICAGO, ILL. 60653

17. Provider #: 14-8243
Print, Type or Stamp

18. Name & Add. of Referring Physician

Dr. Carter
657 W. 79th. St. Chgo, Ill

13. TOTAL CHARGE	$ 105.00
14. CREDIT	$
15. NET CHARGE	$ 105.00

19. DIAGNOSIS or CONDITION:
R/O Sickle Cell Anemia, Renal Disease, Thyroid disease, Hypertention

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify) ______

J. S.

21. *CERTIFICATION*

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges [illegible] by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or [illegible]. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER ______ DATE SIGNED ______

22. FOR SPRINGFIELD OFFICE USE ONLY [illegible]

Special Approval – If Required for Procedure [illegible]: ______

( ) Approved ( ) Not Approved By: ______ Date: ______

DPA 315 (R-8-73)

Appendix 4

RESPONSE* FROM NORTHEAST COMMUNITY HOSPITAL, CHICAGO, ILL.

MEMORANDUM—OCTOBER 1975

To: Subcommittee on Long-Term Care and the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging
From: Northeast Community Hospital, Chicago, Ill.
Subject: Testimony for inclusion in your deliberations

Northeast Community Hospital has been the subject of prior statements presented to your subcommittee on September 26, 1975.

We appreciate the opportunity to enlarge the scope of these statements and to deal with the broad question of alcoholism and list treatment. We also intend to respond to specific misrepresentations brought before your committee. We have chosen to use the word "respond" rather than "answer" because we do not believe there is a need to answer allegations brought by newspaper reporters whose statements are grossly inaccurate and which not only misrepresent, but rely on innuendo and distortion, constituting the worst features of advocacy journalism.

There are three primary factors to be considered in dealing with a hospital and its treatment of alcoholics and related medical problems:

(1) Alcoholism itself and the philosophy and plan of the institution.
(2) Illinois law which is governing.
(3) Specific circumstances regarding allegations made.

To put these issues into perspective, we shall deal with each of the points at some length and in great detail on the following pages.

In order to simplify, we have segmented this testimony to enable you to turn immediately to pertinent sections which are germane to the facts and to the ultimate conclusions of this committee.

RESPONSE TO STATEMENTS MADE ABOUT NORTHEAST COMMUNITY HOSPITAL BY MR. WILLIAM CRAWFORD OF THE CHICAGO TRIBUNE ON SEPTEMBER 26, 1975, BEFORE THE SUBCOMMITTEE ON LONG-TERM CARE AND THE SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE U.S. SENATE SPECIAL COMMITTEE ON AGING

This is not intended to be a technicalities-type defense against Mr. Crawford's statements. We feel no defense of the medical services we provide at Northeast Community Hospital is necessary.

However, his gross inaccuracies and misleading statements betray an incredible lack of sensitivity about the special problems of alcoholism and a tremendous ignorance about the care and treatment prescribed and administered to treat this illness. The record must be set straight on this score so that other reckless individuals within or outside the field of journalism will not make the same mistakes. Mr. Crawford also made some glaring errors concerning the operation of Northeast Community Hospital which are so serious that they demand a response.

As stated earlier in this document, Northeast is comprised of two facilities, one at 6130 N. Sheridan Road, and the other at 6970 N. Clark St., Chicago, only a portion of which is devoted to the medical care of alcoholics. The hospital received an aggregate of $1.6 million in medicaid funds during our 1974 fiscal year from the Illinois Department of Public Aid for all services rendered to all types of patients, and not $2 million as represented by Mr. Crawford. Through omission, Mr. Crawford seemed to imply that the entire medicaid contribution was dedicated to the treatment of alcoholics. In fact, only about 25 percent of the $1.6 million was for this purpose.

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*Portions of this response have been retained in subcommittee files.

Mr. Crawford also implies that Northeast Community Hospital has been getting rich because of these medicaid payments. Actually, a simple inquiry would have revealed to Mr. Crawford that the hospital is only allowed a maximum per diem payment by medicaid of $78.80 per day for the care and treatment of public aid patients. Included in this amount is everything the hospital furnishes the patient—i.e., hospital room, nursing care, meals, anesthesia, operating room, X-rays, laboratory, drugs, tests, therapy, etc. Therefore, all costs, not just room and food, are totaled and an average cost per day per patient (not exceeding the $78.80 figure) is computed by the Illinois Department of Public Aid and paid to the hospital on that basis.

As the distinguished members of this committee are probably aware, the actual cost of providing the medical services outlined above is considerably more than the $78.80 maximum we receive from medicaid. Specifically, if we were to look at the stay of Mr. Crawford at Northeast Community while he was pretending to be an alcoholic, his total bill amounted to $732. Out of that, Northeast Community is entitled only to a maximum reimbursement of $394 from medicaid.

Northeast Community, and most other hospitals, lose money for providing medical services to public aid patients.

Another important figure neglected by Mr. Crawford is the substantial number of patients admitted to our hospital every year who have no means whatsoever to pay for their treatment. They have no hospitalization insurance and do not qualify for medicaid. A sizeable percentage of these patients are cared for in the alcoholism treatment unit and fall into the medical assistance, no grant (MANG) category. (See Exhibit A.)* Because of the nature of this type of patient and the fact that they are either unwilling to register with the department of public aid or are so transient that public aid is unable to track their treatment. Yet, in keeping with medical ethics and public policy of the State of Illinois, we cannot and do not turn these people away.

Many of you may be wondering why we are involved in treating alcoholics and public aid patients if we are not fully reimbursed. While we do believe that we have a very dedicated staff at Northeast Community, there are three practical reasons for providing this treatment. They are:

(1) Illinois law demands that we not turn away any individual, including public aid recipients, seeking medical help.

(2) There is a dramatic need in the city of Chicago and most major cities for programs to medically treat alcoholics. Somebody has to do the job, and there is no overabundance of volunteers for this exceedingly difficult and unglamorous job.

(3) While we are not fully reimbursed for treating public aid patients, their presence in the hospital raises the total patient census and allows us to keep operating expenses down and offer our services less expensively than most other facilities in Chicago.

With regard to the entire episode of Mr. Crawford's stay at the hospital under fraudulent circumstances, it is important to note that we do not question the honesty or sincerity of alcoholics who come to our doors seeking medical assistance. Mr. Crawford seems to find this a questionable practice. However, the legitimate alcoholic and those who have worked in the field find it the only realistic admittance procedure.

Alcoholism is a serious, complex disease. Its consequences are unpleasant and unusually painful to the patient. We are medical personnel, and we cannot imagine why anyone would want to pretend to be an alcoholic. When someone arrives at our institution claiming to be an alcoholic and complaining of the classic symptoms associated with alcoholism, we tend to believe that person is telling the truth. It is not like treating a broken arm or a laceration where it is immediately and plainly obvious if someone is "faking it," although we can't imagine why someone would want to do that either.

The most poignant words with regard to Mr. Crawford's charade came from R. A. Hansen, program coordinator of the alcohol treatment program for the Salvation Army in Chicago. He summed it up best in a letter to Northeast

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*Retained in subcommittee files.

Community supporting our services (see Exhibit B).* We would now like to enter a portion of his letter as part of this written testimony:

"I was not the least bit shocked by the story I read in the *Chicago Tribune* on September 10, 1975. Having been in the field of alcoholism for a number of years and being a recovered alcoholic myself, I have had the displeasure of not only reading but meeting many misinformed individuals who pretend to be doing a service for the community.

"But I do not remember ever hearing of an 'undercover alcoholic.' I cannot for the life of me comprehend what kind of person would feign an illness for the sake of newspaper headlines. Sick, I suppose, but not from drink.

"He began his story by using the word 'cure' which is not found in the vocabulary of the alcoholic therapist, those who work in the field of alcoholism. He continued by referring to the alcoholic as a 'welfare loafer' and from the start I knew at once I had stumbled upon another misinformed person who can never imagine nor be made aware of the disease concept of alcoholism.

"I propose that this task force team do some homework before they venture forth again and add to the already solid wall of distrust the suffering alcoholic has built around himself because of the preconceived notions society has of the illness alcoholism.

"The concern, it seems to me, should be for the alcoholic and not for the money involved or the cleanliness of the facilities. If the money were put into the hands of those interested enough to help, instead of into the hands of the suffering alcoholic, perhaps the few treatment centers in the Chicago area could do no more. But it seems society is more concerned about those who need no physician than those who do.

"The 'undercover reporter' has evidently never sobered up in the back seat of an abandoned car. He probably has not found himself in an alley half beaten to death because he refused to share his last drink with someone. Nor, I suppose, as he shook half to death on the floor of a city jail while the police stood by and watched. I wonder if he has ever held the head of one of his friends while he drowned in his own blood and died of esophageal varices."

There is very little that can be added to the eloquent words of Mr. Hansen, a man who really knows what alcoholism is about and fully understands the need for facilities such as the one at Northeast Community Hospital.

What ignorance and insensitivity is displayed by Mr. Crawford when he testifies to your distinguished committee:

"The only other planned activity during my stay was 'occupational therapy,' an hour-long exercise supervised by an untrained young woman in a small, ill-equipped room where we fumbled about trying to make ceramic ashtrays and other bric-a-brac."

Forget the fact that the "untrained young woman" of whom he was referring was a dedicated person who volunteered to handle the therapy session for several days while we were in the process of hiring a new director for that program. Forget that the primary purpose of that therapy is to get the alcoholic's mind off drinking and give him something constructive to do with his hands. But, it is absolutely abhorrent that Mr. Crawford would ridicule these sick people by saying they were "fumbling about."

Of course they fumbled. They are alcoholics, sick people, suffering from polyneuritis. Many have had convulsions or even more serious medical problems. Mr. Crawford says they fumbled; that is analagous to making fun of a person who suffered a stroke and stumbles while attempting to learn to walk again.

Mr. Crawford, in his statement, talks about "squalid surroundings of the hospital and the substandard, dehumanizing medical care it offers." Yet, the hospital, as recently as July 5 of this year, just 10 days before Mr. Crawford's one-act play began at the hospital, received notification of a full, unqualified 2-year accreditation from the Joint Commission on Accreditation of Hospitals. Both before and after Mr. Crawford's visit and even after his stories, surprise inspections were conducted at the hospital by the Chicago Board of Health, which found no major deficiencies or infractions.

A substantial portion of Mr. Crawford's statement stems from hearsay—things other people told him, but which he never bothered to verify.

For example, Mr. Crawford states that the desk clerk at the LaSalle Hotel telephoned Northeast Community to make a reservation for him at the hospital for the following morning.

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*Retained in subcommittee files.

No one other than a physician on the staff of the hospital can call and make a reservation at Northeast Community Hospital!

Our patients come from referrals from other hospitals, licensed physicians with admitting privileges at our hospital, or recognized community agencies such as the Salvation Army or the Edgewater-Uptown Mental Health Council or on an emergency basis via ambulance or walk-in. We accept no advance reservations. Illinois law and medical ethics, however, prohibit us from turning away anyone who comes through our doors for emergency treatment.

If Mr. Crawford had a penchant for truth and accuracy, he could have called the admitting office at Northeast Community following the desk clerk's purported conversation, to determine, in fact, if there was a reservation in his name at the hospital. He would have discovered this was not the case, but this "investigative reporter" never even bothered to check. He took the word of a man who hands out jugs of wine to alcoholics to keep them in his hotel (as attested to by Mr. Crawford himself).

Mr. Crawford also consumes five paragraphs of his statement by quoting a former hospital employee, whom he indicated worked at Northeast Community as an intake counselor. Such intake counselor was an initiator of at least two labor-related cases against the hospital which were heard before the NLRB. In each case the NLRB found in favor of the hospital. It seems patently unjust for the reporter to rely so heavily on an obviously disgruntled and prejudiced former employee.

You might think that with Mr. Crawford's proclivity for secondhand testimony, he might at some point have been interested in hearing the hospital's side of the story. And, indeed, he did sit with Mrs. June Reichert, a registered nurse and director of patient services at Northeast Community, while she explained to him how the hospital operates and why it does things in a certain way. He listened, but he did not put one of Mrs. Reichert's words into his statement before your committee. In the two stories about Northeast Community in the *Chicago Tribune*, the following is all that was attributed to Mrs. Reichert:

" 'This hospital is not a motel,' June Reichert, a registered nurse who has handled admissions since January, said in an interview."

That's it—the sum total of Mr. Crawford's two hour "interview" with the director of patient services. What has happened to fair and balanced journalism? We didn't dodge, we didn't duck, and we answered all of Mr. Crawford's inquiries promptly and fully as we are prepared to answer those posed by this committee.

If Mr. Crawford was good with hearsay, his innuendo was nothing short of masterful.

Although he would not, or could not, come right out and say it, Mr. Crawford implied throughout his statement that Northeast Community had some underhanded liaison with ambulance companies, transient hotels, or both, to bring patients to our hospital when they either didn't belong there or should have gone elsewhere.

The reason Mr. Crawford could not come right out and say it is because it is untrue. He couldn't prove it; the reason he couldn't prove it is because not a shred of evidence exists, oral or written, circumstantial or otherwise, to document the implication; and, the reason he couldn't find any evidence is simply because the implication is patently and completely false.

Northeast Community Hospital does not now, nor ever has had, any affiliation or agreement, formal or informal, with an ambulance service or transient hotel to provide the hospital with patients.

With no evidence existing, why did Mr. Crawford decide to point a slightly bent finger of guilt at Northeast Community?

Why not delve further into the affairs of ambulance companies, who do make a profit from transporting public aid patients, or of the transient hotels, who try to find ways to keep their customers coming back? Why assume that the hospital was at fault? Were we simply the big, inviting, and convenient target? The ambulance company in this instance received $69 for one-way transportation; the hospital received $78.80 for 24 hours of total care.

Complete information concerning all aspects of Northeast Community Hospital's comprehensive alcoholism treatment program and the hospital's admissions policies is presented to members of the committee in another section of this document (see exhibit C).*

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*Retained in subcommittee files.

Before concluding and without going through Mr. Crawford's entire statement on a paragraph-by-paragraph basis, there are a few other points we feel compelled to correct.

(1) Mr. Crawford states that he was visited by his physician only four times during his stay. That is true. Mr. Crawford was a Northeast Community Hospital for 5 days, having been released on the fifth day. The attending physician visits the patient once every day, except in the event of emergencies or unusual circumstances. Following the physician's visit, he writes on the patient's chart the prescribed medical course of action, which is always carried out by the hospital's staff. This procedure was followed in Mr. Crawford's case. His attending physician saw him daily, prescribed treatment which was carried out to the letter, pronounced him free of symptoms and in good health at the end of the fourth day, and discharged him.

(2) Concerning Mr. Crawford's statement about the manner in which he arrived at the hospital, we cannot, nor do we want to, speak for the ambulance company. It is a fact, though, that anyone can be transported to a hospital by ambulance if they phone the ambulance company and complain of symptoms indicating an emergency medical condition. It is also a fact that, in the normal course of events, the ambulance must radio ahead and, unless the hospital contacted refuses to take the patient due to inavailability of staff or facilities, deliver the patient to the geographically closest hospital. That is so, unless the patient specifically requests the ambulance driver take him to a particular hospital, in which case the ambulance driver take him to a particular hospital, in which case the ambulance must deliver the patient to the hospital of his choice or he is taken to the designated trauma center for certain types of emergencies. Mr. Crawford, in his statement, discusses his little dialog with the ambulance attendants. However, he never does tell us if, in his zealousness to write the story he wanted to write, he might have asked to be taken to Northeast Community.

(3) Mr. Crawford discusses entries on his chart and medication prescribed for him. Mr. Crawford was diagnosed and treated on the basis of his contention that he was an alcoholic and his repeated recitation of symptoms that accompany acute and chronic alcoholism. We have treated many different types of patients (we are, after all, a general hospital) over the years at Northeast Community and encountered some bizarre cases, but we have never before been confronted with someone who faked the symptoms of alcoholism. He said he was an alcoholic, gave us symptoms of an alcoholic, and we had no reason to doubt that he was an alcoholic.

Unlike many detoxification units throughout the country, we, at Northeast Community, have no standing orders for medication. Medication was first prescribed for Mr. Crawford only after a registered nusre noted his symptoms, reached the attending physician by phone, and described those symptoms to him. The doctor prescribed the medication—the same medication every other detoxification unit in the Nation administers to alcoholics. This was done on the basis of Mr. Crawford's self-proclaimed symptoms. Contrary to Mr. Crawford's nonmedical contention, the dosages prescribed were mild, not excessive, and also in accordance with drug dosages administered to alcoholics elsewhere in the country. Of course, any dosage is excessive for a healthy person, but, then, Mr. Crawford said he was sick.

It is a violation of medical ethics for us to make public Mr. Crawford's hospital chart without his permission. If he gives his permission, his contentions will be invalidated and ours sustained.

Since Mr. Crawford is unconvinced about our medical expertise concerning the administration of drugs to patients, and since he said he checked with other "experts" and subsequently testified that, "Others likened the medication to using a shotgun to shoot a fly," we thought you might find the following statement of interest:

"Chlordiazepoxide should be given right away since if one waits for the withdrawal syndrome to be well established, and the patient very agitated, we may giving too little too late. The physician should set the pace so as to stay a little ahead of the patient rather than let him get out of hand and have to pursue his symptoms."

The Chlordiazepoxide referred to above is Librium, one of the drugs administered to Mr. Crawford in accordance with his attending physician's instructions. The origin of the treatment procedure described above is the National Council on Alcoholism's manual entitled: "Treatment of the Alcohol Withdrawal Syndrome."

(4) Mr. Crawford, in his statement, ridicules our alcoholic treatment and therapy programs, calling them a "sham." Mr. Crawford, I am sure, is aware that these therapy sessions are completely voluntary. We can only urge, but cannot force, patients to attend. What Mr. Crawford apparently is unaware of due to his lack of knowledge about the medical treatment of alcoholism, is that it is our responsibility to first treat the patient for withdrawal, something which generally takes 3 days to accomplish. An alcoholic going through withdrawal is an unfit candidate for therapy. Since the Illinois Department of Public Aid says that, under most conditions, we have only a total of 5 days to treat the alcoholic patient, our primary concern must remain withdrawal and the treatment of any physical maladies.

(5) Mr. Crawford apparently disagrees with some of the hospital's programs and policies. However he may disagree, would other hospitals, including some of the most prestigious in Chicago, and agencies like the Salvation Army and the Chicago Council on Alcoholism, continue to send patients to us if they had reason to suspect that Mr. Crawford's statements concerning the quality of medical care being provided or the method of operation being employed at the hospital were true? These hospitals and agencies, with whom we have had longstanding relationships, have faith in what we are doing, and we personally value their conclusions far more than Mr. Crawford's short-term, one-man judgment.

We hope this testimony has given the distinguished members of the committee a clearer view of alcoholism, the problems of treating the alcoholic, the purpose for and services provided by detoxification units and, specifically, the way we operate at Northeast Community Hospital.

We thank you for giving us this opportunity.

Appendix 5

LETTER AND ENCLOSURES FROM JOHN C. McCABE, PRESIDENT, AND BENNETT J. McCARTHY, CHAIRMAN OF THE BOARD, BLUE CROSS AND BLUE SHIELD OF MICHIGAN; TO VAL HALAMANDARIS, ASSOCIATE COUNSEL, SENATE SPECIAL COMMITTEE ON AGING, DATED NOVEMBER 20, 1975

DEAR SIR: On September 26, 1975, Mr. Paul Allen, representing the Michigan Department of Social Services, testified before the special committee on administrative costs and efforts toward curbing program abuse and fraud in the Michigan medical assistance program.

While we have great respect for Mr. Allen and his continuing effort to perform increasingly well in an extremely demanding and difficult job in State government, the testimony which he presented included certain remarks and implications which, in the judgment of Blue Cross and Blue Shield of Michigan, are not consistent with documented facts.

We feel compelled, then, to offer to your committee the attached statement, which is intended to correct the committee's record in these same respects and which offers additional commentary and evidence related to them.

Sincerely,

BENNETT J. MCCARTHY.
JOHN C. MCCABE.

[Enclosures.]

STATEMENT OF BLUE CROSS AND BLUE SHIELD OF MICHIGAN

On September 26, 1975, Mr. Paul Allen, chief deputy director of the Michigan Department of Social Services, testified before the Special Committee on Aging concerning the Michigan experience in curbing fraud and abuse in its medical assistance program. Blue Cross and Blue Shield of Michigan wish to offer the following comments, pertaining to that testimony, for the purpose of clarifying certain of the remarks and data it contained.

From 1966 to 1973, pursuant to a contractual agreement with the State of Michigan, Michigan Hospital Service and Blue Shield of Michigan (now consolidated into Blue Cross and Blue Shield of Michigan and all other references to the corporation in this statement shall reflect its consolidated nature) served as fiscal agents for the Michigan medical assistance program. In its role as fiscal agent, Blue Cross and Blue Shield of Michigan performed the following functions:

—Receipt, adjudication, processing, and payment of claims.
—Provider and professional relations.
—Pre- and post-payment review, audit, and investigation of providers and professionals to assure the appropriateness of program liability.
—Surveys to determine the efficacy of hospital utilization review programs for the medicare and medicaid programs.
—Other administrative duties required by the contract.

In the period of 1969–71, the State of Michigan, with the assistance of an outside consulting firm, developed and submitted for bid a redesigned medicaid processing system. Blue Cross and Blue Shield of Michigan was notified by the State of its selection as the most likely fiscal agent for the redesigned medicaid program. In October 1971, however, the State notified Blue Cross and Blue Shield of Michigan that the Michigan Department of Social Services would act as its own fiscal agent for administration of the medicaid program. The publicized reason for this decision by the State was projected dollar savings in administration, as determined by a government estimate, after receipt and examination of confidential bids from several prospective fiscal agents. Another stated reason for the decision of the State was its desire to effect greater management control over the program and to avoid duplication of functions. Recognizing their own public reponsibility for an orderly transition, and in spite of their conviction that the State's decision was not justified by Blue Cross and Blue Shield performance nor by the State's anticipation of savings, the corporation cooperated fully for approximately 18 months in effecting an orderly transfer of medicaid operations to the State to assure effective payment of benefits on behalf of medicaid program beneficiaries.

The wisdom of the State's decision to assume total administration of the program, however, is not the issue at hand. The principal concerns to your committee are or ought to be the true cost of administering the Michigan medical assistance program and certain additional facts concerning investigation of fraud and abuse in Michigan. We have some observations we wish to share in this regard.

In his description of the scope of the program as presently administered by the Michigan Department of Social Services, Mr. Allen testified to your committee that "administrative costs have been held to only slightly more than 1 percent of total benefit payments, one of the best, if not the best, cost/benefit ratios for all health coverage plans, public and private, in the United States." From information contained in published documents attached and relative to which we comment below, that statement is misleading.

—Reference to Michigan House and Senate appropriations bills, covering fiscal 1975 (attached as exhibits A and B) reveals only two direct elements of administrative cost for medicaid administration: invoice processing and medical surveillance. Amounts appropriated by the legislature for these specific purposes were $5.9 million and $2.7 million respectively, and, added together, the resultant $8.6 million represents 1.4 percent of budgeted benefit payments.

—Also, the "Second Annual Report" of the State of Michigan on the medical assistance program covering calendar 1974 (attached as exhibit C) indicates administrative costs of $.36 per claim line with 29.3 million claim lines processed. This data yields administrative costs of $10.5 million representing 1.8 percent of benefit dollars paid out in calendar 1974.

—Finally, for fiscal 1974, based on the HEW report on State expenditures for medical assistance programs (attached as exhibit D), the State of Michigan reported administrative costs of $22.5 million representing 4.36 percent of benefit payments in fiscal 1974. This $22.5 million is the administrative cost figure reported to the Federal Government by the State of Michigan to obtain reimbursement for the Federal share of the program.

Thus, administrative costs have been expressed as "only slightly more than" 1 percent, 1.4 percent, 1.8 percent, and 4.36 percent for identical or largely overlapping annual periods. These figures present the further problem that they evidently do not relate to identical functional costs. Blue Cross and Blue Shield cannot verify the validity of any one of the figures, but it is clear that the true cost of medicaid administration is certainly not illustrated by the 1 percent figure given in Mr. Allen's testimony.

In 1971, the last full year in which Blue Cross and Blue Shield of Michigan had fiscal agency responsibility for the Michigan medical assistance program, and for those portions of the programs which we administered (as listed above), the corporation incurred administrative costs of 2.95 percent of benefit payments (supportive data contained in exhibits E and F attached).

This figure represented a true administrative cost for program administration by Blue Cross and Blue Shield except for the handling and maintenance of eligibility files, provider certification and program management, which were the responsibility of the department of social services.

It should be apparent, then, when comparability of functions performed is considered, that considerable doubt is cast on the State's assertion that it has succeeded in reducing total administrative costs.

In actuality, and by contrast, it is difficult if not impossible to know what the comparable present costs of program administration by the State may be, not only for the reasons already noted, but also due to the fact that some of the cost basis has changed. The State now has:

—A largely redesigned processing system.

—A computerized eligibility system (as opposed to the almost exclusively manual system maintained by the State when Blue Cross and Blue Shield of Michigan administered other aspects of the program).

As already noted, these systems design changes were accomplished by the department of social services under contractual arrangements with an external consulting firm. That developmental step represents an additional, considerable cost.

Other changes which impact the issue and hand include:

—A payment process which does not include many of the prepayment controls employed by Blue Cross and Blue Shield of Michigan.

—Involvement of additional State agencies whose budgets are approved separately and whose services to medicaid may not be reported as such.

We also believe that it is important for your committee to be aware of certain facts not referenced in Mr. Allen's testimony on the efforts of the State of Michigan to curb program abuse and fraud in medicaid. The testimony received by your committee implies that these same functions were not performed effectively by Blue Cross and Blue Shield of Michigan and that the systems and procedures related to them are of the State's own invention.

Such implications run completely counter to documented fact.

Even prior to the advent of medicare and medicaid, Blue Cross and Blue Shield of Michigan had devised, maintained, and continued to refine its own audit and investigative functions and routinely performed audits and investigations for its own business.

These functions were expanded considerably by our corporation after 1966 to handle the increased workload resulting from our new role as fiscal intermediary under both medicare and medicaid. We utilized steadily increasing computer capacity to help improve the effectiveness of these functions and, in 1971, for example, performed more than 3,000 separate audits for the medicaid program alone (supportive data drawn from "Medicaid and Michigan Blue Shield" and attached as exhibit G). By contrast, the State handled only 371 medicaid investigations in fiscal year 1974–75 (data drawn from tab D of the report of the medicaid investigation section provided to the committee by Mr. Allen). By way of further comparison, Blue Cross and Blue Shield of Michigan obtained over $1 million in refunds in 1971 out of $176.6 million in benefit payments, which is approximately the same amount, but some 200 percent higher, proportionately, than the $1 million recovered by the State in 1974–75 out of over $500 million in benefit payments.

Blue Cross and Blue Shield of Michigan is gratified to have been able to originate the conceptual basis for the design and initial implementation of this audit and investigative program. Perhaps the value of our corporate contribution in this respect is illustrated best by the clear modeling of the State's audit and investigation function on the original Blue Cross and Blue Shield of Michigan function. The latter was made possible because Blue Cross and Blue Shield of Michigan personnel spent mony hours explaining to State personnel the Blue Cross and Blue Shield of Michigan system, as well as educating them to our techniques for developing investigations and concerning past investigations performed for the medicaid program. In other words, without the active assistance of Blue Cross and Blue Shield of Michigan, the State would have been able to attain its present degree of sophistication only with considerable difficulty and additional expense. It is also worth noting that Blue Cross and Blue Shield of Michigan still conducts audits and investigations for its own business and for the government programs which it administers.

The supplemental material provided to the committee by Mr. Allen covering the audit and investigation function references, under tab D, both refund dollars and projected savings. To characterize the latter as "savings" cannot be justified except by assuming that audits and fraud investigations have a measurable impact on future benefit payout. It is clear that the investigation of suspected program abuse and fraud can have an impact on benefit payout in three ways:

—Recoveries.

—Correction of abusive practices.

—Deterrent effects.

While the amount of recoveries obtained through audits and investigations is obviously measurable in specific dollar terms, it must be noted that corrective actions taken and deterrent effects that may result from such activities have a potential dollar impact which cannot be measured accurately, if at all. It is enough to know that such impact occurs. However, it is improper and misleading to claim actual savings under either of these headings since they cannot be documented.

On the issue of prepayment controls referenced earlier, the State has projected potential annual savings of $20 million following its intended implementation of a prepayment screening process for hospital bills. As fiscal agents for medicaid, Blue Cross and Blue Shield of Michigan conducted prepayment screening with documented savings of over $4 million in 1972 (supportive data drawn from "1972–73: A Report on Medicaid," prepared by Blue Cross and Blue Shield of Michigan and attached as exhibit H). The ongoing employment of this prepayment screening process caused Blue Cross and Blue Shield of Michigan to incur in their administrative costs (as cited earlier) expenses which have not been incurred previously by the State, because it has only now begun to implement the process. Thus, the State's original estimate of savings on administrative costs may not be an accurate indication of relative efficiency. Failure to perform a function which is designed to monitor the appropriateness of payments will indeed reduce administrative cost but tends to increase benefit payout.

In summary, while the State's efforts to improve its capacities as medicaid agent are welcome, it is our belief that the committee can benefit from these additional facts relative to the matters about which the State's testimony was given. It should be obvious that activities like audit and fraud investigations, by whatever name they are identified, are not unique to the medicaid program but, rather, have been integral elements of Blue Cross and Blue Shield programs for an even longer period of time. Moreover, experience, as well as an examination of the varying bases for the administrative cost figures cited earlier, could suggest to the committee the need that it define more precisely what constitutes true administrative costs and savings.

If the committee desires further input from Blue Cross and Blue Shield of Michigan, we would, of course, be most willing to testify or submit additional materials on administrative costs, investigation of fraud and program abuse or any other matter pertinent to the deliberations of the committee and within the realm of Blue Cross and Blue Shield of Michigan expertise.

Act No. 241
Public Acts of 1974
Approved by Governor
7/26

Exhibit A

STATE OF MICHIGAN
77TH LEGISLATURE
REGULAR SESSION OF 1974

Introduced by Reps. Copeland and Farnsworth
Reps. Kehres and Nelson named as co-sponsors

ENROLLED HOUSE BILL No. 5640

AN ACT to make appropriations for the department of social services and certain state purposes related to public welfare services for the fiscal year ending June 30, 1975; to provide for the expenditure of such appropriations; and to provide for the disposition of fees and other income received by the various state agencies.

The People of the State of Michigan enact:

Sec. 1. There is appropriated for the department of social services and certain state purposes related to public welfare as herein set forth for the fiscal year ending June 30, 1975, from the funds as identified hereunder:

General fund	$ 825,740,362.00
Federal funds	766,473,851.00
Housing authority funds	3,864,128.00
Miscellaneous other funds	8,461,250.00
Total Gross Appropriations	$ 1,604,539,591.00

or as much thereof as may be necessary for the several purposes in the following respective amounts:

DEPARTMENT OF SOCIAL SERVICES
ADMINISTRATIVE SERVICES

This program provides administrative leadership and supplies staff services for the department through the following component programs.

Executive Direction

Provides executive leadership for the department, and provides fair hearings for clients.

	For Fiscal Year Ending June 30, 1975	
Director	$ 34,495.00	
Youth and adult advisory commission	11,400.00	
Chief administrator	31,250.00	
Deputy director	31,250.00	
Deputy director	31,250.00	all
Salaries and wages—not to exceed 62 positions	1,001,700.00	part of all
Longevity and insurance	57,100.00	
Retirement	207,875.00	other.

		For Fiscal Year Ending June 30, 1975	
Contractual services, supplies and materials	245,000.00		
Equipment	5,000.00		
Travel	43,526.00		
Subtotal	$ 1,699,846.00		
DEPARTMENTAL SERVICES			
Administrative Support Services			
This program is designed to insure fiscal accountability, efficient management of information, paper flow, personnel, staff development, internal program evaluation, and socio-economic information to assist administrators.			
Salaries and wages - not to exceed 473.4 positions	$ 5,653,100.00		part
Longevity and insurance	305,612.00		
Retirement	1,039,469.00		
Contractual services, supplies and materials	1,018,600.00		
Equipment	68,520.00		
Travel	131,800.00		
MYSIS project	394,900.00		
Grants to universities	845,000.00		
Subtotal	$ 9,457,001.00		
Health and Welfare Data Center			
This state data center provides the department with data processing support services including systems design, computer programming, computer processing, and data reduction.			
Salaries and wages - not to exceed 519.1 positions	$ 5,962,808.00		part
Longevity and insurance	327,983.00		
Retirement	1,096,585.00		
Contractual services, supplies and materials	5,663,924.00		
Equipment	13,402.00		
Travel	42,882.00		
Subtotal	$ 13,107,584.00		
Medicaid Administration			
This bureau administers the medicaid program to include bill processing for payout and audits of medical providers.			
Salaries and wages - not to exceed 284.0 positions	$ 3,243,086.00		all
Longevity and insurance	173,443.00		
Retirement	585,787.00		
Contractual services, supplies and materials	1,416,035.00		
Equipment	62,430.00		
Travel	175,854.00		
Common audit contract	275,000.00		
Subtotal	$ 5,931,635.00		
~~Subtotal Administrative Services~~	~~$ 30,196,066.00~~		
Less:			
Federal funds	$ 17,249,531.00		
LEAA funds—MYSIS project	355,400.00		
Federal funds to universities	633,750.00		
University funds	211,250.00		
SUBTOTAL ADMINISTRATIVE SERVICES		$ 11,746,135.00	

Recipient Eligibility in here.

ADULT, FAMILY AND YOUTH SERVICES

Operations and Administration

Program Direction and Support

Activities in this program include coordination and centralized direction for the effective delivery of social services and income maintenance on the state, regional, county, and district levels.

	For Fiscal Year Ending June 30, 1975
Salaries and wages - not to exceed 1,777.6 positions	$ 15,945,641.00
Longevity and insurance	873,791.00
Retirement	2,920,047.00
Contractual services, supplies and materials	1,223,858.00
Equipment	87,684.00
Federal county rent	1,800,000.00
Travel	95,190.00
Subtotal	$ 22,946,211.00

Inspector General

This office investigates all cases of alleged fraud and administers the child support collections program for the department.

Salaries and wages - not to exceed 100.8 positions	$ 1,292,602.00
Longevity and insurance	70,242.00
Retirement	226,458.00
Contractual services, supplies and materials	126,574.00
Equipment	36,352.00
Legal support contracts	5,300,000.00
Travel	96,621.00
Subtotal	$ 7,148,849.00

Assistance Payments Administration

This program is responsible for policy development, administration, and the eligibility determination for all public assistance programs including food stamps, medicaid, and direct relief.

Salaries and wages - not to exceed 3,754.1 positions	$ 39,627,920.00
Longevity and insurance	2,122,646.00
Retirement	7,270,687.00
Contractual services, supplies and materials	4,940,711.00
Equipment	400,049.00
Travel	345,367.00
Subtotal	$ 54,707,380.00

Quality Control

Quality control includes a statewide review of a sample of assistance cases and negative case actions to determine that client eligibility and amount of grant are correct. These reviews include a full field investigation of each sample case.

Salaries and wages - not to exceed 143.0 positions	$ 1,987,031.00
Longevity and insurance	108,050.00
Retirement	362,383.00
Contractual services, supplies and materials	148,228.00
Equipment	17,920.00

	For Fiscal Year Ending June 30, 1975
Travel	139,330.00
Subtotal	$ 2,762,940.00

Administrative Support Services and Licensing

Provides central and regional staff which coordinate and direct field staff in the areas of adult, family, children, and youth services. Also included in this appropriation unit is the staff required to license child welfare facilities and adult foster care facilities.

Salaries and wages - not to exceed 264.6 positions	$ 3,822,499.00
Longevity and insurance	206,973.00
Retirement	691,734.00
Contractual services, supplies and materials	620,299.00
Equipment	34,494.00
Travel	217,622.00
Juvenile training council	362,800.00
Subtotal	$ 5,956,421.00

Self Support Services

This program is part of the single social services system which provides employment and training services, and family services to eligible families. Day care is also provided to enable individuals to maintain employment, seek employment, or participate in training programs.

Salaries and wages - not to exceed 703.8 positions	$ 9,032,600.00
Longevity and insurance	487,000.00
Retirement	1,658,400.00
Contractual services, supplies and materials	692,200.00
Equipment	42,900.00
Travel	472,116.00
Day care	34,611,100.00
WIN administration	75,000.00
Subtotal	$ 47,071,316.00

Basic Social Services for Children, Families, and Adults

Part of the single social services system which provides social services to families and adults and assistance to neglected and delinquent youth within the community.

Salaries and wages - not to exceed 2,351.3 positions	$ 28,396,410.00
Longevity and insurance	1,531,771.00
Retirement	5,207,292.00
Contractual services, supplies and materials	2,419,062.00
Equipment	133,160.00
Travel	1,447,558.00
Manpower information and services for troubled youth	175,000.00
Decentralization project - LEAA	1,512,300.00
Project adult	85,700.00
Donated funds	20,000,000.00
Adult home help	12,780,000.00
Family home help	3,300,000.00
Family planning	1,500,000.00

	For Fiscal Year Ending June 30, 1975
Transportation to sheltered workshops	665,500.00
Subtotal	$ 79,153,753.00
Subtotal Operations and Administration	$219,746,870.00
Less:	
Federal funds	$125,811,525.00
Federal match donated funds	15,000,000.00
LEAA funds - manpower information and services for troubled youth	157,500.00
LEAA funds - project adult	77,100.00
LEAA funds - juvenile training	326,500.00
County funds	3,250,000.00
Local donated funds	5,000,000.00
Subtotal Operations and Administration	$ 70,124,245.00

Residential Care for Children and Youth

Part of the single social services system which includes the operation and administration of group facilities for neglected and delinquent children and youth including halfway houses, small group homes, shelter homes, a diagnostic and short-term treatment center in Ann Arbor, youth rehabilitation camps, and training schools in Adrian and Whitmore lake.

Salaries and wages - not to exceed 673.2 positions	$ 7,971,600.00
Longevity and insurance	428,100.00
Retirement	1,463,600.00
Contractual services, supplies and materials	1,652,900.00
Equipment	72,600.00
Travel	61,984.00
Special maintenance	63,000.00
Foster care payments	14,575,041.00
Institutional improvement	25,000.00
Decentralization project	163,300.00
Project STEADY	93,900.00
Special group homes project	259,200.00
Community residential care	$ 945,800.00
Subtotal	$ 27,776,025.00
Less:	
Federal funds	$ 6,321,448.00
LEAA funds - institutional improvement	22,500.00
LEAA funds - STEADY - PPC	84,500.00
LEAA funds - community residential care	851,200.00
LEAA funds - special group homes project	233,300.00
Subtotal Residential Care for Children and Youth	$ 20,263,077.00

Rehabilitation of the Blind

This program offers services of diagnosis, provisions of medical aid and artificial appliances, teaching and counseling, vocational training, job placement, work supervision, and follow-up services.

Salaries and wages - not to exceed 106.3 positions	$ 1,265,700.00
Longevity and insurance	68,900.00
Retirement	232,300.00

	For Fiscal Year Ending June 30, 1975
Contractual services, supplies and materials	82,500.00
Equipment	5,000.00
Travel	75,736.00
Case services	900,000.00
Facilities program	200,000.00
Vending stand retirement	67,600.00
Subtotal	$ 2,897,736.00
Less:	
Federal funds	$ 2,278,273.00
Subtotal Rehabilitation of the Blind	$ 619,463.00

Direct Support

Financial assistance is provided for families with dependent children, individuals and families who do not qualify for federal programs, and supplemental benefits are provided for the aged, blind, and disabled.

Aid to families with dependent children total standard	$700,392,600.00
Recipient earned and other income	56,000,000.00
Child support collections	50,000,000.00
Aid to families with dependent children grants	594,392,600.00
Supplemental security income	62,109,100.00
Direct relief grants	56,050,000.00
Family emergency assistance grants	3,750,000.00
Adult emergency assistance grants	1,000,000.00
Subtotal	$717,301,700.00
Less:	
Federal funds	$301,402,300.00
Subtotal Direct Support	$415,899,400.00

Medical Services

Provides medical care to the categorically needy—the aged, disabled, blind, and dependent children, as well as the medically indigent—those categorically related people whose resources are above the categorical assistance level but not enough to pay for medical care.

Hospital services and therapy	$212,684,300.00
Physician services	88,908,118.00
Medicare premium payments	6,115,692.00
Pharmaceutical	49,853,764.00
Home health services	649,800.00
Transportation	2,139,300.00
Auxiliary medical services	37,131,500.00
Nursing home services	
Nursing homes total	175,474,700.00
Patient pay	31,400,000.00
Subtotal nursing homes	$144,074,700.00
Homes for the aged total	8,201,900.00
Patient pay	2,090,000.00
Subtotal homes for the aged	$ 6,111,900.00
Chronic care units and county medical care facilities	47,632,275.00
Patient pay	6,363,300.00
Subtotal chronic care units and county medical care facilities	$ 41,268,975.00
Subtotal nursing homes services	$191,455,575.00
Subtotal	$588,938,049.00
Less:	
Federal funds	$294,469,024.00

benefits

		For Fiscal Year Ending June 30, 1975
Subtotal Medical Services	$294,469,025.00	
SUBTOTAL ADULT, FAMILY AND YOUTH SERVICES		$801,375,210.00

FINANCIAL AND TECHNICAL AID TO COMMUNITIES

Housing

This bureau has the goal of providing adequate dwellings for low and moderate income families at a price they can afford.

Housing development authority	$ 2,500.00	
Salaries and wages - not to exceed 136.0 positions	1,922,800.00	
Longevity and insurance	104,500.00	
Retirement	352,700.00	
Bond and note issuance cost	300,000.00	
Contractual services, supplies and materials	1,029,300.00	
Equipment	23,500.00	
Travel	128,828.00	
Subtotal	$ 3,864,128.00	
Less:		
Fees and charges	$ 3,864,128.00	
Subtotal Housing	$ -0-	

Juvenile and Child Care Services

The purpose of providing funds for child care is to enable each county juvenile court to provide the necessary care for children under its jurisdiction. The juvenile officers portion of this program is to assure each of the juvenile courts staff to provide needed services. The range of services includes such activities as adoption and foster home planning and placement and meeting the needs of dependent children either prior to, or instead of, commitment to this department.

Child care total	$ 33,515,717.00	
County payments	21,028,900.00	
Child care grants	$ 12,486,817.00	
Juvenile officers	1,332,200.00	
Subtotal	$ 13,819,017.00	
Less:		
Federal funds	$ 1,200,000.00	
Subtotal Juvenile and Child Care Services	$ 12,619,017.00	
SUBTOTAL FINANCIAL AND TECHNICAL AID TO COMMUNITIES		$ 12,619,017.00
TOTAL DEPARTMENT OF SOCIAL SERVICES		$825,740,362.00

Sec. 2. (1) The amounts appropriated shall be paid out of the state treasury at such times and in such manner as is or may be provided by law.

(2) Each of the amounts appropriated shall be used solely for the respective purposes herein stated except as otherwise provided by law. To assure the design and installation of a performance budgeting program and provide periodic and interpretative financial data upon which legislative decisions may be made, the appropriations contained in this act shall be allotted, where applicable, on the basis of component and subcomponent programs and all expenditures shall be reported and recorded as per object code classifications and in conformance with section 12 of Act No. 51 of the Public Acts of the First Extra Session of 1948, as amended, being section 18.12 of the Michigan Compiled Laws.

Notwithstanding the provisions of Act No. 95 of the Public Acts of 1965, being sections 21.251 to 21.255 of the Michigan Compiled Laws, none of the money appropriated by this act shall be used to pay prior year's bills, obligations, or encumbrances, except contract printing of the house of representatives and any recognized liability for refurbishing of the senate.

(3) Fees and other moneys received by the various departments, commissions, boards, agencies, and offices, for whom appropriations are made by this act, shall, except as otherwise provided by this act, or other acts, be promptly forwarded to the state treasurer and credited to the general fund.

Sec. 3. Where a continuing appropriation exists for any item or purpose under any law of this state, and an appropriation is also contained in this act for the same item or purpose, this act shall supersede the continuing appropriation during the fiscal year ending June 30, 1975.

Sec. 4. When appropriations are made herein from restricted revenues, including federal and matching revenues but excepting direct federal pass-through revenues to local governmental units, the amount to be expended from the restricted revenue shall not exceed the amount herein appropriated or the amount paid in, together with any balances carried forward during the fiscal year ending June 30, 1975, whichever is the lesser. If matching revenues are received in an amount less than the appropriation contained herein, the general fund portion of the appropriation shall be reduced in proportion to the amount of matching revenue received. All restricted revenue received, including federal, matching, and pass-through revenue, shall be detailed, by department and program, and forwarded to the appropriations committees before March 1, 1975.

Sec. 5. No state agency shall establish new programs nor expand programs including any program involving federal or other funds, beyond the scope of those already established, recognized, and appropriated by the legislature, until such program and the availability of money shall be submitted by each agency to the budget director for recommendation to the legislature and until each program has been authorized and funds appropriated therefor by the legislature.

All moneys received as grants, subsidies, or in any form whatever from the federal government in payment of overhead expenses shall be deposited in the state general fund and shall be expended only upon appropriation by the legislature.

Appropriations under this act made in contemplation of matching federal or other funds shall not be expended until federal or other matching funds are available. The acceptance of such funds does not obligate the state to continue programs after the federal or other funds are no longer available. A report of the program, receipts, and expenditures shall be furnished the chairmen of the senate and house appropriations committees and included in the annual budget document, pursuant to section 6a of Act No. 98 of the Public Acts of 1919, being section 21.6a of the Michigan Compiled Laws.

Sec. 6. At the close of the fiscal year the unencumbered balance of each appropriation made in this act shall revert to the general fund, except for balances of appropriations derived from other funds, in which case the balances shall revert to those funds from which financing was provided, in accordance with the provisions of Act No. 95 of the Public Acts of 1965.

Sec. 7. The appropriations made under the provisions of this act for unclassified positions as specified by a line item appropriation shall be used for such positions. Incumbents of such positions in the executive branch of state government shall be eligible to participate in the state contributory insurance program on the same basis as classified employees.

All other acts or parts of acts to the contrary notwithstanding, it is the intention of the legislature that those unclassified officials whose salaries are specified by this act shall receive the amount of salary herein specified.

The appropriations for salaries and wages shall be used only with respect to classified positions established by the civil service commission and none of the money appropriated herein shall be used to pay back salaries or wages to any employee.

None of the funds appropriated in this act shall be expended in payment of salaries for new or additional positions, whether or not such new or additional positions are created by reallocations or by reclassification, nor for any contractual contracts covering consultant services and contractual personnel unless the budget director certifies the moneys for these purposes were included within the funds appropriated.

By March 1 of each fiscal year an itemized report covering data on such contractual service contracts shall be furnished by the budget director to the senate and house appropriations committees.

Sec. 8. (1) Except for grants to individuals, retirement, longevity and insurance, intertransfers, authorized by section 6 of Act No. 2 of the Public Acts of 1921, as amended, being section 17.6 of the Michigan Compiled Laws, within appropriations for any particular department or institution, shall not be made which will increase or decrease any item of appropriation by more than 3% or $10,000.00, whichever is greater, and an item of appropriation shall not be increased or decreased by more than $50,000.00 in the aggregate, nor shall any transfer be made into any salary and wage account.

(2) Other than those transfers specified in subsection (1), a transfer of appropriations including any which might arise as a result of the implementation of the state of Michigan management information

system (SOMMIS) master plan shall not be made unless and until approval of the transfer is first recommended by the state budget director and, while the legislature is in session, is authorized by concurrent resolution or when the legislature is not in session, approval is then secured from the special commission on appropriations created under the provisions of Act No. 120 of the Public Acts of 1937, as amended, being sections 5.1 to 5.5 of the Michigan Compiled Laws.

(3) Transfers made under this section shall be reported by the budget director within 30 days to the senate and house appropriations committees.

Sec. 9. From the appropriations herein made there is appropriated such sums of money as shall be necessary to meet the required assessments from specific accounts or sources to the civil service commission, to the state employees or other retirement funds, and for other significant authorized fringe benefits such as longevity and insurance programs. Each department head, in compliance with procedures established by the director of the department of management and budget shall deposit in the appropriate fund an amount sufficient to meet the civil service and all employees retirement fund assessments and the employer's cost of longevity and sponsored insurance programs for all funds received and expended from sources other than those appropriated in this act.

Sec. 10. No administrative or personnel services, which services by virtue of section 5 of article 11 of the state constitution are the responsibility of the civil service commission, or services in connection with the insurance policies maintained by the civil service commission, shall be performed by department employees paid from funds appropriated by this act, unless such services are fully financed through a contract voluntarily entered into by the civil service commission and the respective department. All revenues resulting from any such contract shall be deposited in the general fund.

Sec. 11. Whenever a physician prescribes a dehumidifier for an eligible medicaid recipient who is afflicted with emphysema, medicaid funds appropriated in section 1 of this act may be utilized to pay for this appliance.

Sec. 12. When it appears to the governor, based upon written information received by him from the director of the department of management and budget and the department of treasury, that actual revenues for a fiscal period will fall below the revenue estimates on which appropriations for that period were based, the estimates being as determined by the legislature in accordance with section 31 of article 4 of the state constitution of 1963, the governor shall make a finding that actual revenue for that fiscal period, will fall below such revenue estimates. The governor shall then order the director to review all appropriations made by the legislature, except those made for the legislative and judicial branches of government or from funds constitutionally dedicated for specific purposes.

Based upon needs, the director of the department of management and budget shall recommend to the governor a reduction of expenditures authorized by such appropriations, either direct or open-ended, for that fiscal year. The governor shall review the recommendations of the director and shall prepare his order containing reductions in expenditures authorized so that actual revenues for the fiscal period will be sufficient to equal the expenditures. The governor shall give not less than 5 days' written notice to the members of the appropriations committees of the house and senate specifying a time and place for a joint meeting of the governor and the 2 committees, at which the governor shall present to the committees his recommendations and copies of his proposed order.

Not later than 10 days after submission of the order to the committees, each committee by vote of a majority of its members elected and serving shall approve or disapprove the order. Approval of both appropriations committees is required before any expenditures authorized by appropriations shall be reduced. Upon approval by both appropriations committees, the director shall carry out and implement the order.

If either or both appropriations committees disapproves the order, the order is without force and effect. Not later than 30 days after any disapproval of a proposed order, the governor may give reasonable written notice to the members of the appropriations committees of the house and senate as to the time and place of a further joint meeting of the 2 committees at which time he shall resubmit an order reducing expenditures authorized by appropriations. Within 10 days of the receipt of the order by the appropriations committees, each committee shall by a majority of its members elected and serving, approve or disapprove the order. A copy of the order of the governor and resolutions of both the appropriations committees approving it shall be filed with the secretary of state and the order shall become effective.

Sec. 13. To implement executive order 1973-7, the department of management and budget shall assume the powers, fulfill the duties, and perform the functions specified in section 5a of Act No. 51 of the Public Acts of the First Extra Session of 1948, being section 18.5a of the Michigan Compiled Laws.

Subject to the approval of the director of the department of management and budget, agencies with excess reserve data processing capacity are authorized to furnish data processing services beyond those authorized in this act. Such additional costs incurred to provide services are to be financed by charges made to requesting agencies.

Before exercising authority to approve the acquisition and use of electronic data processing equipment, including support services, communications, maintenance, and associated ancillary systems, it shall be the responsibility of the department of management and budget to assemble and submit for consideration of the joint computer and data processing subcommittee of the house and senate appropriations committees, the studies, planning data, proposal requests, and procurement instruments related to such acquisition.

All the provisions contained herein are subject to review and approval or disapproval by the joint computer and data processing subcommittee of the house and senate appropriations committees.

Sec. 14. In addition to the appropriations for the fiscal year ending June 30, 1975, the legislature appropriates from the state funds contained herein to state agencies any amounts necessary to pay court judgment rendered under chapter 64 of Act No. 236 of the Public Acts of 1961, as amended, being sections 600.6401 to 600.6475 of the Michigan Compiled Laws.

Sec. 15. The amounts appropriated in section 1 of this act for LEAA programs shall not revert to the general fund at the conclusion of the 1974-75 fiscal year, but shall continue to be available for expenditure until the projects for which they were appropriated are completed or otherwise terminated. At the conclusion of the 1975-76 fiscal year, the unencumbered balance for each completed or terminated project shall revert to the general fund and any unearned federal funds received for the completed or terminated project shall be returned.

Each department director having an appropriation for LEAA funds shall notify the director of the department of management and budget as to the June 30, 1975 status of each project for which LEAA appropriations have been made. This notification shall be made by the following August 1, and shall be in sufficient detail so that the director of the department of management and budget can cause the unencumbered balance of the completed or terminated projects to be reverted to the general fund.

Sec. 16. On January 30 and July 30 of each year, each department head shall submit a listing to the appropriations committees of the house of representatives and the senate with a copy submitted to the house and senate fiscal agencies, of every person who received compensation, fees, or remuneration of any type under the provisions of this act, for the preceding 6 months, of all travel outside the state. This listing shall include name, location, reason for and dates of travel, and all transportation and related costs. The above listing shall be accompanied by a statement by the department head reflecting the total in-state travel for the same periods.

Sec. 17. When federal or state funds appropriated in section 1 of this act are to be expended for any meeting (conference or seminar) that involved more than 10 state employees (collectively from one department) necessitating travel from their home counties, written notice to include the reason for the meeting (conference or seminar), duration, number of participants, location, time, date, total federal and/or state cost, and the account from which the meeting (conference or seminar) will be financed shall be transmitted to the members of the senate and house appropriations committees not later than 15 days prior to the meeting date, with a copy submitted to the senate and house fiscal agencies.

Sec. 18. All moneys received as grants, subsidies, or in any form whatever from the federal government in payment of overhead expenses shall be deposited in a separate account which shall either lapse into the state general fund or be expended through the regular appropriating process.

Sec. 19. It is the intent of the legislature that when recipients of public assistance are paid more than the amount to which they are legally entitled that the department of social services shall reduce subsequent grants in an amount that will insure repayment of the overpayment. The director of the department shall establish reasonable limits on the proportion of the payments that may be deducted, so as not to cause undue hardship on recipients.

Sec. 20. The department of social services may contract with nonprofit or local public agencies established to provide community services and residential services to youth.

Sec. 21. The funds appropriated in this act for nursing home services are to be expended for 2 types of care classified as follows: skilled nursing home care and intermediate, also known as basic nursing home care.

Facilities providing care under these programs shall adopt uniform accounting procedures, uniform cost reporting, and submit patient status data and cost information to the director of the department of social services annually in accordance with the principles of reimbursement and cost reporting forms approved by the auditor general. This information shall be treated as confidential and used for purposes of program evaluation and establishing of and verification of nursing home rates. All statistical and accounting records are subject to audit.

Nursing homes shall be reimbursed on an individual home basis. Costs will be determined retrospectively in accordance with the allowable cost items included in the principles of reimbursement as approved by the auditor general.

The reimbursement rates to which individual nursing homes shall be entitled will include allowable operating expenses determined in accordance with the above principles, plus a fixed profit allowance for proprietary homes of $1.75 per patient day. The rates shall not exceed the ceilings of $20.95 per patient day for skilled nursing care patients and $19.35 per patient day for intermediate nursing care (basic care) patients from July 1, 1974, through December 31, 1974, and $21.35 and $19.70 respectively from January 1, 1975, through June 30, 1975. The ceilings shall be further increased on July 1, 1975, to $21.75 and $20.05 respectively.

For July 1, 1974, through December 31, 1974, the portion of the reimbursement rate for allowable operating expenses per patient day shall not exceed 107.5% of an individual facility's next fiscal year per patient day costs retrospectively adjusted to June, 1974; nor shall it exceed 109.5% of the adjusted June, 1974, per patient day costs for the period January 1, 1975, through June 30, 1975; nor shall it exceed 111.5% of the June, 1974, per patient day costs thereafter. The June, 1974, adjusted per patient day costs shall be determined by the retrospective application of the Detroit all items index to individual nursing home facilities' per patient day costs as determined from facilities' fiscal year cost reports for the fiscal year ending during the period from July 1, 1974, through June 30, 1975.

The director shall not authorize reimbursement to any facility which refuses the medical evaluation of medical patients by designated representatives of the department of social services or does not comply with the reporting and all attendant schedules thereto of this section.

The director of the department shall establish daily reimbursement rates for nursing care facilities. From the appropriations made in section 1 of this act, the state shall pay for nursing care in chronic care units of general hospitals and county medical care facilities daily rates as determined by the director of the department plus 40% of the difference between that rate and the total cost audited for the institution in those facilities where the total daily costs exceed the determined rate.

The director of the department shall establish reimbursement rates for nursing care in mental health facilities.

To effect the early implementation of those sections of Public Law 92-603 which require the skilled nursing care benefits of titles XVIII and XIX to become comparable, the department of social services shall negotiate agreements with the secretary of health, education and welfare under which the state of Michigan will assume responsibility for prior authorization and continuing medical review of any person to receive skilled nursing care under the above defined programs, and to utilize the reimbursement formula herein adopted as the method of reimbursement to be used for title XVIII on an experimental basis. It is the intent of the legislature that the state of Michigan make every effort to ensure an orderly transition to the skilled nursing care provisions of Public Law 92-603.

Sec. 22. Prior to November 15, 1974, the department of public health, the department of social services, and the inter-association committee shall develop a nursing home payments program for implementation after January 1, 1976, which will include incentives for cost containment and will provide for an equitable profit factor.

Sec. 23. As a condition of the appropriation contained in section 1 for direct relief, county expenditures for county medical institutions shall not be considered general relief for the purpose of state participation, notwithstanding present provisions of section 18 of Act No. 280 of the Public Acts of 1939, as amended, being section 400.18 of the Michigan Compiled Laws.

Sec. 24. State funds shall not be distributed to any county, city, or district department of social services for direct relief unless and until the rules and regulations, any amendments thereto or supplemental thereof, of the county, city, or district department of social services, are filed with the state department of social services and in the distribution of state funds no cases shall be included in which direct relief is granted in violation of the rules and regulations so filed.

Notwithstanding the provisions of section 81 of Act No. 306 of the Public Acts of 1969, as amended, being section 24.281 of the Michigan Compiled Laws, procedures in this agency's contested cases shall be in accordance with the provisions of section 9 of Act No. 280 of the Public Acts of 1939, as amended, being section 400.9 of the Michigan Compiled Laws.

Sec. 25. After the effective date of this act, as a condition of the appropriation contained in section 1 for single direct relief and family direct relief, county expenditures for general relief to supplement categorical aid recipients shall not be matched by the state except for emergencies and medical needs in accordance with such guidelines for any item or items that may be established by the director of the department of social services and by no other elective or appointive state official. Such director shall also have exclusive authority to implement such guidelines and mandamus shall not obtain to compel such implementation. The general relief payments to categorical aid recipients, except for emergency and medical needs, shall not be considered general relief for the purpose of state participation, notwithstanding present provisions of section 18 of Act No. 280 of the Public Acts of 1939, as amended.

Sec. 26. Any other provisions of the law notwithstanding, any recognized liability within a period not to exceed 12 months for medical care related to title XIX and for institutional services and medical care facilities related to public assistance may be paid from the appropriations made in this act.

Sec. 27. Notwithstanding the limitations of section 18b of Act No. 280 of the Public Acts of 1939, being section 400.18b of the Michigan Compiled Laws, the director shall establish statewide uniform daily reimbursement rates for the foster and institutional care of children. During the fiscal year 1974-75, reimbursement of foster or institutional care funded in whole or in part by the appropriations in section 1 shall be consistent with the uniform rate established by the director.

Sec. 28. A county receiving state matching funds for the foster care of children from the appropriations in section 1 shall submit reports to the director of the department of social services at least quarterly. The reports shall be submitted on forms provided by the director and shall include the number of children receiving foster care services and the number of days of care that have been provided. It shall be the responsibility of each county receiving state matching funds for the foster care of children to provide the director, at such times and on forms provided by him, with reports including the status of the plan for the return of each child to his natural parent, the placement of each child for adoption, or other permanent placement plans for each child.

Sec. 29. Institutional providers which are cost settled under the medicaid program are required to submit cost reports within 90 days of their fiscal year end. In the event that the provider fails to submit such report, the department may reduce or suspend payments.

Sec. 30. Subject to the approval of the director of the management sciences group of the executive office, agencies with excess reserve data processing capacity may furnish data processing service beyond those authorized in this act. Such additional costs incurred to provide services are to be financed by charges made to requesting agencies.

Sec. 31. The amounts appropriated in section 1 of this act for community services shall include the provision of precourt child protective services in all counties and court protective services upon agreement with the probate court and within the limits of this appropriation.

Sec. 32. The department of social services shall provide an administrative procedure for the review of grievances by nursing homes with regard to the daily reimbursement rate for that facility as established in accordance with section 20 of this act.

Sec. 33. Any other provisions of the law notwithstanding, expenditures against 1974-75 appropriations for the medicaid title XIX program, except for administration and operation, shall be based on billings paid by the department of social services from July 1, 1974, through June 30, 1975. Statements of expenditures and financial reports shall be prepared on this basis.

Sec. 34. During the fiscal year 1974-75, the director of the department of social services and the director of the Michigan employment security commission shall enter into cooperative arrangements for the maximum utilization of the job placement and other services and facilities of the employment security commission. Such arrangement shall include the assignment of employment security personnel to selected county departments of social services. The director of social services shall submit quarterly reports to the governor and members of the legislature concerning the numbers of public assistance recipients and applicants employed as a result of this cooperative arrangement.

Sec. 35. It is the intent of the legislature that the department shall establish 1 unit to license both adult and child care facilities.

Sec. 36. Any person eligible for public or medical assistance shall have freedom of choice in his placement into a long-term care or adult foster facility.

Sec. 37. An adult recipient of aid or relief, excluding supplemental security income recipients, shall be required to be available to accept such work in his community as he is able to perform. Any recipient under aid for dependent children or general assistance who has a child under 6 years of age shall be excluded from the requirements of this section if adequate day care facilities are not available.

Sec. 38. The director shall cause to be submitted to each recipient of public assistance an itemization of the amounts authorized in the recipient's basic budgetary allowance once each year and at any time that the budget allowance of the recipient is adjusted.

Sec. 39. Any other law to the contrary notwithstanding, the department shall be exempt from the provisions of chapter 4 of Act No. 306 of the Public Acts of 1969, as amended, being sections 24.271 to 24.287 of the Michigan Compiled Laws. Procedures in this department's contested cases shall be in accordance with the provisions of federal regulations governing fair hearings for the public assistance programs.

Sec. 40. Prior to November 15, 1974, the department shall study the feasibility of using title VI funds for the partial reimbursement of adult foster care facilities. If it is determined that title VI funds are available for state match the department shall use a portion of the moneys appropriated for supplemental security income in section 1 of this act to match federal funds to finance the adult foster care rate as determined by the legislature.

Sec. 41. County departments of social services shall require all recipients of general assistance who have applied with the social security administration for supplemental security income to sign a contract to repay any assistance rendered through the general assistance program upon their receipt of retroactive supplemental security income benefits.

Sec. 42. The department shall submit a comprehensive training proposal to the chairmen of the house and senate appropriations committees prior to November 15, 1974.

Sec. 43. The number of full-time equated positions allocated in section 1 to the basic social services program may be exceeded by 100 positions to the extent that the additional positions are filled with paraprofessional personnel.

Sec. 44. Notwithstanding the provisions of section 14(m) of Act No. 280 of the Public Acts of 1939, as amended, being section 400.14 of the Michigan Compiled Laws, funds in the amount of $50,000.00 have been included in the executive direction, contractual services, supplies and materials account in section 1 of this act to enable the department to contract with or otherwise engage legal representation in pursuit of such legal actions as the director deems appropriate.

Sec. 45. The funds appropriated for prevention and diversion in the basic social services account are for implementation of preventive demonstration projects for children and youth in jeopardy of entering the juvenile justice system. The funds may be utilized as local or state match of federal funds.

Sec. 46. The maximum limits on payments under the medicaid program, established in conformance with section 1903 of title XIX of the social security act shall be available only to persons directly responsible for the administration of the medicaid program.

Sec. 47. The department shall apply the 7.5% aid to families with dependent children update to the personal needs and household needs components of the standard in a manner which will maximize recipient benefits from aid to families with dependent children and other assistance programs.

Sec. 48. If it is determined that revenue estimates for the fiscal year 1974-75 are increasing at a rate that indicates a sufficient projected surplus, the department of management and budget shall submit a proposal to the chairmen of the house and senate appropriations committees recommending that the protected income level for medicaid coverage be increased to 120% of the related public assistance standard for the period of January 1, 1975, through June 30, 1975.

Sec. 49. If a recipient of public assistance has defaulted on rental or home purchase payments by the equivalent of 1 or more monthly payments, the department of social services shall institute vendor payments for the portion of the assistance payment budgeted for rent or home purchase. In addition, the total assistance provided to such client shall be made a protective payment if deemed necessary by the department of social services.

Sec. 50. In order to promote more effective management of the department of social services, the director of the department may utilize up to 20 state office positions from any appropriations account for functions in other state office units which the director deems to be more critical to the management of departmental programs.

Sec. 51. The protected income level for medicaid coverage shall be 110% of the related public assistance standard for the fiscal year 1974-75.

Sec. 52. To promote a uniform statewide program for food stamp distribution, the department may enter into contracts with the U.S. postal service to issue food stamps. The county share of food stamp issuance costs shall not exceed 30% and shall be considered a direct relief expenditure for purposes of section 18 of Act No. 280 of the Public Acts of 1939, being section 400.18 of the Michigan Compiled Laws.

Sec. 53. Any other section of this act notwithstanding, whenever it appears, for any reason, that expenditures for the aid to dependent children program will exceed the appropriation in section 1 of this act for that program, the director of the department of social services shall request a supplemental appropriation or authority to transfer funds from the legislature before the expenditures to implement the additional cost are expended.

This act is ordered to take immediate effect.

Thos Thatcher

Clerk of the House of Representatives.

Beryl I. Kenyon

Secretary of the Senate.

Approved ....

....

Governor.

Act No. 234
Public Acts of 1974
Approved by Governor
July 26, 1974

Exhibit B

STATE OF MICHIGAN
77TH LEGISLATURE
REGULAR SESSION OF 1974

Introduced by Senator Zollar for the Appropriations Committee

ENROLLED SENATE BILL No. 1178

AN ACT to make appropriations for the department of public health; to provide for the expenditure of such appropriations; and to provide for the disposition of fees and other income received by various state agencies.

The People of the State of Michigan enact:

Sec. 1. There is appropriated for the department of public health for the fiscal year ending June 30, 1975, from the funds identified hereunder:

General fund	$ 31,059,100.00
Federal funds	43,146,800.00
Various other fees and revenues	2,143,300.00
Total Gross Appropriations	$ 76,349,200.00

or as much thereof as may be necessary for the several purposes in the following respective amounts:

		For Fiscal Year Ending June 30, 1975
DEPARTMENT OF PUBLIC HEALTH		
Executive		
Provides leadership in planning, implementing and evaluating the public health policies and programs.		
Director	$ 39,500.00	
Assistant to the director	28,000.00	
Salaries and wages—not to exceed 4.0 positions	44,100.00	
Longevity and insurance	4,500.00	
Retirement	20,100.00	
Contractual services, supplies and materials	13,200.00	
Travel	6,900.00	
Revision and codification of public health statutes	75,000.00	
Equipment	1,900.00	
Subtotal	$ 233,200.00	
Less federal funds	25,000.00	
SUBTOTAL EXECUTIVE		$ 208,200.00

part

ADMINISTRATIVE SERVICES PROGRAM

This bureau is responsible for administrative leadership and providing staff services for the department through the following component programs.

For Fiscal Year Ending June 30, 1975

Management Services

Responsibilities include personnel administration, fiscal management, office services, health information training, health statistics.

Salaries and wages—not to exceed 53.5 positions	$ 686,400.00	
Longevity and insurance	42,600.00	
Retirement	127,100.00	
Contractual services, supplies and materials	160,600.00	
Travel	20,500.00	
Equipment	1,400.00	
Special maintenance	11,800.00	
Operation and maintenance of new building	125,000.00	
New office building moving expense	30,000.00	
Subtotal	$ 1,205,400.00	
Less federal aid:		
Public health service	63,700.00	
Maternal and child health	38,500.00	
Indirect	332,100.00	
Title IVa	63,400.00	
Subtotal	$ 707,700.00	

part

Statistics and Vital Records

Provides for the coordination, development and operation of mechanized information systems. Records and maintains health statistics, population data, records of births, deaths, marriages, divorces, and adoptions.

Salaries and wages—not to exceed 90.3 positions	$ 992,300.00	
Longevity and insurance	60,200.00	
Retirement	183,400.00	
Contractual services, supplies and materials	284,200.00	
Travel	11,700.00	
Equipment	1,600.00	
Vital records project (1.0 position)	10,300.00	
Federal statistical grant (15.0 positions)	359,700.00	
Subtotal	$ 1,903,400.00	
Less federal aid:		
Public health service	323,200.00	
Maternal and child health	22,100.00	
Indirect	62,500.00	
Direct federal	370,000.00	
Subtotal	$ 1,125,600.00	

part

Information and Education

Produces and coordinates publications, provides graphic art services, operates the department library and recruits personnel for the agency.

Salaries and wages—not to exceed 15.5 positions	$ 202,200.00	
Longevity and insurance	11,900.00	
Retirement	38,000.00	
Contractual services, supplies and materials	49,200.00	
Travel	2,100.00	
Equipment	700.00	
Federal training program (2.0 positions)	130,100.00	
State training program	20,000.00	
Physical fitness (2.0 positions)	35,100.00	
Physicians assistants program (2.0 positions)	38,500.00	
Subtotal	$ 527,800.00	
Less federal aid:		
Public health service	179,300.00	
Maternal and child health	55,700.00	
Subtotal	$ 292,800.00	
SUBTOTAL ADMINISTRATIVE SERVICES		$ 2,126,100.00

part

		For Fiscal Year Ending June 30, 1975
HEALTH CARE ADMINISTRATION		
Objective—primary responsibility is to carry out medical surveillance of medicaid (Title XIX) under contract with the department of social services in order to assure appropriate cost for medicaid recipients.		
Salaries and wages—not to exceed 107.6 positions	$ 1,368,800.00	
Longevity and insurance	55,200.00	
Retirement	244,800.00	
Contractual services, supplies and materials	63,700.00	
Travel	69,200.00	
Equipment	21,400.00	
Rent	76,800.00	
Dental program (29.0 positions)	531,000.00	
Medical review and nursing evaluation	329,200.00	
Subtotal	$ 2,760,100.00	
Less federal aid:		
Title XIX	2,014,600.00	
SUBTOTAL HEALTH CARE ADMINISTRATION		$ 745,500.00

all

HEALTH FACILITIES		
This bureau is concerned with health planning, construction, operation, licensing and certification.		
Executive and medical coordination		
Provides executive direction and medical consultation for both the planning and construction program and standards and licensing programs.		
Salaries and wages—not to exceed 13.5 positions	$ 277,500.00	
Longevity and insurance	10,800.00	
Retirement	50,900.00	
Contractual services, supplies and materials	39,300.00	
Travel	15,100.00	
Rent	23,600.00	
Equipment	1,800.00	
Emergency medical service (10.0 positions)	232,300.00	
Subtotal	$ 651,300.00	
Less federal aid:		
Title XIX	90,900.00	
Title XVIII	128,300.00	
Highway safety	110,800.00	
Subtotal	$ 321,300.00	

part

Health Facilities—Planning and Construction		
Objective is to develop a coordinated system of high quality health care institutions and services providing reasonable access for all people without unnecessary duplication.		
Salaries and wages—not to exceed 19.8 positions	$ 285,600.00	
Longevity and insurance	15,700.00	
Retirement	51,900.00	
Contractual services, supplies and materials	26,900.00	
Travel	11,900.00	
Equipment	7,500.00	
Regional federal review grant	291,300.00	
Hill-Harris administration	50,000.00	
Federal participation in Hill-Harris administration program is estimated at $50,000.00, however, the state general fund participation shall be increased in the same amount as federal funds may be decreased.		
Hill-Harris construction	13,500,000.00	
Subtotal	$ 14,240,800.00	
Less federal aid:		
Direct federal	13,915,900.00	
Subtotal	$ 324,900.00	

?

		For Fiscal Year Ending June 30, 1975
Less federal aid:		
Public health service	670,000.00	
Maternal and child health	395,400.00	
Title XVIII	19,500.00	
Direct federal	522,500.00	
Subtotal	$ 5,129,800.00	
Disease Control Services		
Objective is to prevent or control communicable and chronic disease, and in the case of tuberculosis to assure treatment.		
Salaries and wages—not to exceed 60.4 positions	$ 823,100.00	
Longevity and insurance	44,000.00	
Retirement	151,700.00	
Contractual services, supplies and materials	92,800.00	
Travel	33,900.00	
Tuberculosis aid	2,015,700.00	
Diabetes study	15,000.00	
Kidney program (1.0 position)	500,000.00	
(Federal participation in the kidney program is estimated, however, the state general fund participation shall be increased in the same amount as federal funds may be decreased up to a maximum of $200,000.00.)		
Direct federal projects (33.0 positions)	1,112,600.00	
Vaccines	512,500.00	
Immunizations	145,000.00	
Cancer control	300,000.00	
Subtotal	$ 5,746,300.00	
Less federal aid:		
Public health service	287,800.00	
Maternal and child health	86,400.00	
Direct federal	1,802,400.00	
Subtotal	$ 3,569,700.00	
Regional Health		
Salaries and wages—not to exceed 15.0 positions	$ 377,800.00	
Longevity and insurance	14,200.00	
Retirement	67,800.00	
Contractual services, supplies and materials	17,200.00	
Travel	20,800.00	
Subtotal	$ 497,800.00	
Less local funds	230,500.00	
Less federal aid	218,800.00	
Subtotal	$ 48,500.00	
SUBTOTAL COMMUNITY HEALTH		$ 8,748,000.00
MATERNAL AND CHILD HEALTH		
This bureau is concerned with the prevention and treatment of health problems of mothers and children.		
Administrative Services		
Coordinates and evaluates special projects conducted at the local level such as clinics, screening services, program consultation and treatment supervision.		
Salaries and wages—not to exceed 8.0 positions	$ 159,300.00	
Longevity and insurance	7,400.00	
Retirement	29,500.00	
Contractual services, supplies and materials	11,900.00	
Travel	4,500.00	
Equipment	500.00	
Rent	62,100.00	
Crib death autopsies (this appropriation is contingent upon the passage of H.B. 5505)	50,000.00	
Mental retardation projects	226,000.00	

For Fiscal Year Ending June 30, 1975

Family planning (11.0 positions)	2,678,300.00
Local benefits (1.0 position)	306,500.00
Subtotal	$ 3,536,000.00
Less federal aid:	
Maternal and child health	484,000.00
Direct federal	2,804,300.00
Subtotal	$ 247,700.00

Preventive Services

Special attention is given to expectant mothers and infants in low income areas where adequate prenatal and postnatal care are lacking, including prevention of speech disorders of preschool children.

Salaries and wages—not to exceed 33.0 positions	$ 537,700.00
Longevity and insurance	26,300.00
Retirement	99,100.00
Contractual services, supplies and materials	54,000.00
Travel	40,600.00
Equipment	4,600.00
Maternity and infant care project (23.0 positions)	3,800,000.00
(Federal participation is estimated at $2,761,600.00 total, including $480,000.00 IVa funds, however, state general fund participation shall be increased in the same amount as federal funds may be decreased.)	
Lead paint	100,000.00
Research and testing sickle cell disease	175,000.00
Preschool youth and adolescent comprehensive health services (1.0 position)	3,570,000.00
Subtotal	$ 8,407,300.00
Less federal aid:	
Maternal and child health	874,400.00
Title XIX	1,130,000.00
Title IVa	480,000.00
Direct federal	4,685,000.00
Subtotal	$ 1,237,900.00

Part of benefits

Treatment Services

Objective is to locate children with crippling conditions and to insure medical attention to permit their fullest possible development.

Salaries and wages—not to exceed 103.4 positions	$ 1,203,700.00
Longevity and insurance	72,700.00
Retirement	221,800.00
Contractual services, supplies and materials	144,300.00
Travel	38,100.00
Equipment	3,000.00
Rent	41,700.00
Staff training	7,300.00
Diagnostic clinics	37,100.00
Medical care and treatment	7,822,700.00
Amputee program (7.0 positions)	281,000.00
Bequests	50,000.00
Conveyor contract	248,400.00
Developmental disabilities (4.0 positions)	776,000.00
Regional perinatal care—evaluation and training	39,700.00
Subtotal	$ 10,987,500.00
Less federal aid:	
Crippled children	1,936,800.00
Title XIX	2,526,100.00
Direct federal	1,057,000.00
Less collections	180,000.00

		For Fiscal Year Ending June 30, 1975
Less bequests	$ 50,000.00	
Subtotal	$ 5,237,600.00	
SUBTOTAL MATERNAL AND CHILD HEALTH		$ 6,723,200.00
ENVIRONMENTAL HEALTH		
This bureau strives to assure an attractive, comfortable, convenient and health environment by controlling pollution, and reducing health and safety hazards.		
General Environmental Health		
This program attempts to prevent environmental degradation through licensing migrant workers housing, trailer parks.		
Salaries and wages—not to exceed 30.0 positions	$ 503,400.00	
Longevity and insurance	24,100.00	
Retirement	83,800.00	
Contractual services, supplies and materials	50,500.00	
Travel	39,200.00	
Equipment	500.00	
Rent	16,200.00	
Food service sanitation (10.0 positions)	199,200.00	
Migrant housing (1.0 position)	150,000.00	
Migrant labor camps (13.0 positions)	252,300.00	
Aerobic septic tank study	20,000.00	
Subtotal	$ 1,339,200.00	
Less federal aid:		
Public health service	108,100.00	
Subtotal	$ 1,231,100.00	
Water Supply		
Objective is to assure that public water supplies, public swimming pool conditions and ground water quality are not hazardous to the health of users.		
Salaries and wages—not to exceed 26.0 positions	$ 402,100.00	
Longevity and insurance	20,300.00	
Retirement	71,800.00	
Contractual services, supplies and materials	20,900.00	
Travel	22,500.00	
Equipment	1,900.00	
Boards and commission	2,500.00	
Subtotal	$ 542,000.00	
Less public health service funds	143,900.00	
Subtotal	$ 398,100.00	
SUBTOTAL ENVIRONMENTAL HEALTH		$ 1,629,200.00
INDUSTRIAL HEALTH		
General Occupational Health		
The program purposes are to prevent occupational disease through surveillance of industries with hazardous working conditions and to assure workers' occupational health care.		
Salaries and wages—not to exceed 93.2 positions	$ 1,284,100.00	
Longevity and insurance	73,200.00	
Retirement	235,700.00	
Contractual services, supplies and materials	155,900.00	
Travel	108,000.00	
Equipment	59,400.00	
Rent	1,300.00	
Monitoring grant	10,000.00	
Subtotal	$ 1,927,600.00	
Less federal aid:		
Public health service	175,500.00	
Direct federal	784,900.00	
Subtotal	$ 967,200.00	

Occupational Health Technical Supporting Services

Provides essential laboratory service to the occupational health program including such things as air samples, maintaining instruments and illustrating corrective procedures.

		For Fiscal Year Ending June 30, 1975
Salaries and wages—not to exceed 14.0 positions	$ 177,600.00	
Longevity and insurance	11,600.00	
Retirement	32,200.00	
Contractual services, supplies and materials	9,800.00	
Travel	1,400.00	
Equipment	19,800.00	
Subtotal	$ 252,400.00	
Less federal aid	126,100.00	
Subtotal	$ 126,300.00	
SUBTOTAL INDUSTRIAL HEALTH		$ 1,093,500.00

LABORATORIES

This bureau provides laboratory services to the public through physicians and health officers. It conducts research relative to improving health and certifies all clinical laboratories.

Administrative and Supporting Services

Serves as a central resource for the administrative and service needs of the laboratory, including purchase of supplies, equipment and media and the maintenance and protection of equipment and buildings.

Salaries and wages—not to exceed 106.8 positions	$ 1,205,700.00
Longevity and insurance	79,400.00
Retirement	223,600.00
Contractual services, supplies and materials	565,200.00
Travel	4,000.00
Equipment	14,200.00
Special maintenance	12,500.00
Grant project support (2.0 positions)	101,200.00
Subtotal	$ 2,205,800.00
Less federal aid:	
Indirect federal aid	101,200.00
Subtotal	$ 2,104,600.00

Labroatory Diagnosis

Provides information to physicians and health officers to control communicable diseases and the quality of the environment and conduct tests for law enforcement officials.

Salaries and wages—not to exceed 166.6 positions	$ 2,056,500.00
Longevity and insurance	124,800.00
Retirement	376,600.00
Contractual services, supplies and materials	93,100.00
Travel	17,700.00
Equipment	128,200.00
Kent county agreement (3.0 positions)	49,900.00
Pesticides (12.0 positions)	212,000.00
Crime laboratory (10.0 positions)	286,800.00
Subtotal	$ 3,345,600.00
Less federal aid:	
Public health service	508,500.00
Direct federal	595,100.00
Less private	49,900.00
Subtotal	$ 2,192,100.00

Biological Products Production

Produces biological products for immunization against infectious diseases, sera and gamma globulin, antigens and blood products.

For Fiscal Year Ending June 30, 1975

Salaries and wages—not to exceed 74.9 positions	$ 992,900.00	
Longevity and insurance	61,700.00	
Retirement	185,800.00	
Contractual services, supplies and materials	156,900.00	
Travel	4,800.00	
Equipment	56,100.00	
Hemophilia (1.0 position)	61,400.00	
Rabies vaccine (2.0 positions)	25,000.00	
Red Cross (2.0 positions)	32,900.00	
Bovine plasma (4.0 positions)	95,000.00	
Anthrax (1.0 position)	10,000.00	
Intravenous gamma globulin	71,200.00	
Subtotal	$ 1,753,700.00	
Less federal aid:		
Direct federal	201,200.00	
Less private	32,900.00	
Subtotal	$ 1,519,600.00	
Inspection and Registration		
Improves local laboratory service through licensing, inspection, proficiency testing and training of laboratory personnel.		
Salaries and wages—not to exceed 10.0 positions	$ 150,600.00	
Longevity and insurance	7,700.00	
Retirement	24,800.00	
Contractual services, supplies and materials	5,400.00	
Travel	3,300.00	
Equipment	700.00	
Subtotal	$ 192,500.00	
Less federal—Title XVII	52,600.00	
Subtotal	$ 139,900.00	
Cancer Products Development		
Develops anti-cancer agents that will control and destroy malignant cells once they appear.		
Salaries and wages—not to exceed 21.2 positions	$ 298,200.00	
Longevity and insurance	17,900.00	
Retirement	55,100.00	
Contractual services, supplies and materials	54,500.00	
Travel	200.00	
Equipment	18,600.00	
Cancer contract (4.0 positions)	52,500.00	
Subtotal	$ 497,000.00	
Less federal aid:		
Direct federal	52,500.00	
Subtotal	$ 444,500.00	
SUBTOTAL LABORATORIES		$ 6,400,700.00
TOTAL DEPARTMENT OF PUBLIC HEALTH		$ 31,059,100.00

Sec. 2. There is appropriated for a substance abuse services program and for certain state purposes related thereto for the fiscal year ending June 30, 1975, from the funds identified hereunder:

General fund	$ 8,695,400.00
State restricted funds	4,351,200.00
Federal funds	4,784,100.00
Total Gross Appropriations	$ 17,830,700.00

or as much thereof as may be necessary for the several purposes and in the following respective amounts:

DEPARTMENT OF PUBLIC HEALTH

Office of Substance Abuse Services

Administration

Administrator	$ 29,000.00
Salaries and wages—not to exceed 39.5 positions (includes 6 federal positions)	560,200.00

		For Fiscal Year Ending June 30, 1975
Longevity and insurance	$ 27,800.00	
Retirement	97,600.00	
Contractual services, supplies and materials	73,400.00	
Travel	34,500.00	
Equipment	3,200.00	
Advisory commission expense and per diem (11 members not to exceed 12 meetings at $35.00 per day)	8,900.00	
Direct federal project	93,200.00	
Public education program	91,500.00	
Training programs and regional workshops	417,000.00	
Incidence and prevalence study	93,000.00	
Evaluation and data system	221,000.00	
Subtotal	$ 1,750,300.00	
Less:		
Federal alcohol funds	399,700.00	
Federal drug funds	253,300.00	
Federal highway safety funds	48,600.00	
State restricted funds	365,900.00	
Subtotal Administration	$ 682,800.00	
Community Drug Treatment Grants	$ 7,493,100.00	
Less:		
Federal NIMH funds	906,600.00	
(The expenditure of state funds is contingent upon maintenance of local funding for the program at the 1973-74 level, except that this provision shall not apply to any local funding in excess of 25% of the total program.)		
Subtotal Drug Treatment Grants	$ 6,586,500.00	
(The above appropriations include state appropriation funds of $1,019,300.00 to provide direct drug treatment services and administrative support services for the operation of the drug abuse center—Detroit.)		
Community Alcoholism Treatment Grants	$ 7,015,100.00	
Less:		
Federal alcoholism funds	2,718,800.00	
Federal highway safety funds	311,000.00	
State restricted funds	3,985,300.00	
Subtotal Community Alcoholism Treatment Grants	$ -0-	
Total Office of Substance Abuse Services	$ 7,269,300.00	
Laboratories		
Laboratory diagnosis—drug alcohol analysis		
Salaries and wages—not to exceed 1.0 positions	$ 13,100.00	
Longevity and insurance	800.00	
Retirement	2,400.00	
Contractual services, supplies and materials	2,000.00	
Contractual drug analysis program	60,000.00	
Alcohol test program	16,800.00	
Total Laboratories	$ 95,100.00	
TOTAL DEPARTMENT OF PUBLIC HEALTH		$ 7,364,400.00
DEPARTMENT OF MENTAL HEALTH		
Lafayette Clinic		
Salaries and wages—not to exceed 9.7 positions	$ 185,400.00	
Longevity and insurance	7,200.00	
Retirement	33,900.00	
Contractual services, supplies and materials	24,800.00	
Total Lafayette Clinic	$ 251,300.00	
TOTAL DEPARTMENT OF MENTAL HEALTH		$ 251,300.00
DEPARTMENT OF EDUCATION		
Substance Abuse Prevention and Education Program		
Salaries and wages—not to exceed 3.0 positions	$ 50,200.00	

		For Fiscal Year Ending June 30, 1975
Longevity and insurance	$ 2,300.00	
Retirement	6,400.00	
Contractual services, supplies and materials	23,400.00	
Travel	2,000.00	
Regional substance abuse education and prevention program	446,000.00	
(The expenditure of these state funds are contingent upon a local support equal to 25% of the total program. These appropriations are intended to continue the 1973-74 regional drug education program with a revised formula for distribution of state funds.)		
Training program	87,500.00	
Student service center grants	52,500.00	
Evaluation of regional substance abuse education and prevention program	25,000.00	
Subtotal	$ 695,300.00	
Less federal funds	69,000.00	
Total Substance Abuse Prevention and Education	$ 626,300.00	
TOTAL DEPARTMENT OF EDUCATION		$ 626,300.00
DEPARTMENT OF CORRECTIONS		
Drug Abuse Treatment Program	$ 144,800.00	
TOTAL DEPARTMENT OF CORRECTIONS		$ 144,800.00
DEPARTMENT OF SOCIAL SERVICES		
Adolescent Drug Use Limitation and Treatment Project	$ 85,700.00	
Special Youth Services	300,000.00	
(These funds are appropriated to provide contractual residential and community services for youth and young adults suffering from drug abuse or other character disorders.)		
Subtotal	$ 385,700.00	
Less federal funds	77,100.00	
TOTAL DEPARTMENT OF SOCIAL SERVICES		$ 308,600.00
TOTAL SUBSTANCE ABUSE SERVICES PROGRAM		$ 8,695,400.00

Sec. 3. (1) The amounts appropriated shall be paid out of the state treasury at such times and in such manner as is or may be provided by law.

(2) Each of the amounts appropriated shall be used solely for the respective purposes herein stated except as otherwise provided by law. To assure the design and installation of a performance budgeting program and to provide periodic and interpretative financial data upon which legislative decisions may be made, the appropriations contained in this act shall be allotted, where applicable, on the basis of component and subcomponent programs, and all expenditures shall be reported and recorded as per object code classifications and in conformance with section 12 of Act No. 51 of the Public Acts of First Extra Session of 1948, as amended, being section 18.12 of the Michigan Compiled Laws.

Notwithstanding the provisions of Act No. 95 of the Public Acts of 1935, being sections 21.251 to 21.255 of the Michigan Compiled Laws, none of the money appropriated by this act shall be used to pay prior year's bills, obligations, or encumbrances, except contract printing of the house of representatives and any recognized liability for refurbishing of the senate.

(3) Fees and other moneys received by the various departments, commissions, boards, agencies, and offices, for whom appropriations are made by this act, shall, except as otherwise provided by this act, or other acts, be promptly forwarded to the state treasurer and credited to the general fund.

Sec. 4. Except as otherwise provided by law, when it appears that any appropriation made in this act for any department, instrumentality, or agency of state government shall be exceeded before the expiration of the fiscal year for which by reason of periodic allotments thereof, recommended for approval by the budget director to the state administrative board, which, if continued to the end of the fiscal year, will exceed the amount of such appropriation, each department, instrumentality or agency shall bring the expenditures within the limits of the appropriations made to the department, instrumentality or agency. The budget director, with the approval of the state administrative board, may at any time reduce or adjust allotments for reasons of administrative efficiency, including those determined by appointing authorities under section 5 of article 11 of the state constitution of 1963. A statement reflecting all reductions or adjustments to allotments made under the authority of this section shall be detailed and forwarded to the appropriations committee before March 1, 1975.

Sec. 5. Where a continuing appropriation exists for any item or purpose under any law of this state, and an appropriation is also contained in this act for the same item or purpose, this act shall supersede the continuing appropriation during the fiscal year ending June 30, 1975.

Sec. 6. Except as otherwise provided by law, where the amount appropriated in this act is less than the amount called for or required to be distributed by existing law, the state official, or body responsible for the administration of the particular appropriation shall reduce the payments under the appropriation made in this act upon a pro rata basis in a manner that the payments shall not exceed the appropriations contained in this act.

Sec. 7. (1) In addition to appropriations contained in this act, federal and other funds may be received and expended pursuant to certification by the head of the recipient department, instrumentality, or agency, that the funds do not require state appropriations either for matching purposes or to continue programs after the funds become unavailable. The funds shall be allotted for expenditure only after approval by the state administrative board upon recommendation of the state budget director. Authorizations approved under this provision shall be reported by the state budget director monthly to the senate and house appropriations committees, with a copy forwarded to the house and senate fiscal agencies.

(2) In addition to appropriations contained in this act, federal and other funds which require state appropriations either for matching or to continue programs after such funds become unavailable, shall be authorized for expenditure pursuant to enactment of a supplemental appropriation. The head of the recipient department, instrumentality, or agency shall submit a request for the authorization to the state budget director in a manner prescribed by him for evaluation and recommendation to the legislature.

Sec. 8. At the close of the fiscal year the unencumbered balance of each appropriation made in this act shall revert to the general fund, except for balances of appropriations derived from other funds, in which case the balances shall revert to those funds from which financing was provided, in accordance with the provisions of Act No. 95 of the Public Acts of 1965.

Sec. 9. The appropriations made under this act for unclassified positions as specified by a line item appropriation shall be used for such positions. Incumbents of such positions in the executive branch of state government, the legislative auditor general's office, and judicial officers whose total compensation is payable by the state and who are not eligible to receive additional compensation from any county, township, or municipal governmental unit of this state under the provisions of the constitution or statutes of this state, shall be eligible to participate in the state contributory insurance program on the same basis as classified employees.

It is the intent of the legislature that those unclassified officials whose salaries are specified by this act shall receive only the amount of salary specified in this act.

The appropriations for salaries and wages shall be used only with respect to classified positions established by the civil service commission and none of the money appropriated in this act shall be used to pay back salaries or wages to any employee.

It is the intent of the legislature that none of the funds appropriated in this act shall be expended in payment for upgrading the salaries of personnel by reallocation or reclassification, or for new or additional positions, whether or not such new or additional positions are created by reallocations or reclassifications, unless prior notice of intent to reallocate or reclassify was specifically expressed to the budget director during the annual budget process by a statement noting the grades or classifications involved, the estimated number of positions within each grade or classification, and an estimate of probable cost to fund the reallocations or reclassifications and unless the budget director certifies that sufficient moneys for these purposes are included within the funds appropriated and that additional funds will not be required for the subject salary and wage accounts by transfer or supplemental appropriation. Funds appropriated in this act shall not be used to cover contractual service contracts covering consultants' services or contractual personnel unless the budget director certifies that moneys for these purposes are also included in the funds appropriated.

By March 1 of each year an itemized report on intended departmental reallocations or reclassifications and contractual service contracts shall be furnished by the director of each state department to the senate and house appropriations committees, with a copy to the senate and house fiscal agencies.

Sec. 10. (1) Except for grants to individuals, retirement, longevity and insurance, intertransfers, authorized by section 6 of Act No. 2 of the Public Acts of 1921, being section 17.6 of the Michigan Compiled Laws, within appropriations for any particular department or institution, shall not be made which will increase or decrease any item of appropriation by more than 3% or $10,000.00, whichever is greater, and an item of appropriation shall not be increased or decreased by more than $50,000.00 in the aggregate, nor shall any transfer be made into any salary and wage account.

(2) Other than those transfers specified in subsection (1), a transfer of appropriations including any which might arise as a result of the implementation of the state of Michigan management information system (SOMMIS) master plan shall not be made unless and until approval of the transfer is first recommended by the state budget director and, while the legislature is in session, is authorized by concurrent resolution or, when the legislature is not in session, approval is then secured from the special commission on appropriations created under Act No. 120 of Public Acts of 1937, as amended, being sections 5.1 to 5.5 of the Michigan Compiled Laws.

(3) Transfers made under this section shall be reported by the budget director within 30 days to the senate and house appropriations committees.

Sec. 11. From the appropriations made in this act there is appropriated such sums of money as shall be necessary to meet the required assessments from specific accounts or sources to the civil service commission, to the state employees or other retirement funds, and for other significant authorized fringe benefits such as longevity and insurance programs. Each department head, in compliance with procedures established by the director of the department of management and budget shall deposit in the appropriate fund an amount sufficient to meet the civil service and all employees retirement fund assessments and the employers' cost of longevity and sponsored insurance programs for all funds received and expended from sources other than those appropriated in this act.

Sec. 12. Any administrative services provided by department employees paid from funds appropriated by this act in connection with the different insurance policies maintained by the civil service commission of any personnel administrative service which services by virtue of section 5 of article 11 of the state constitution of 1963 are the responsibility of the civil service commission, shall be financed through a contract with the civil service commission. All revenues resulting from the contracts shall be deposited in the general fund.

Sec. 13. When it appears to the governor, based upon written information received by him from the director of the department of management and budget and the department of treasury, that actual revenues for a fiscal period will fall below the revenue estimates on which appropriations for that period were based, the estimates being as determined by the legislature in accordance with section 31 of article 4 of the state constitution of 1963, the governor shall make a finding that actual revenue for that fiscal period, will fall below such revenue estimates. The governor shall then order the director to review all appropriations made by the legislature, except those made for the legislative and judicial branches of government or from funds constitutionally dedicated for specific purposes.

Based upon needs, the director of management and budget shall recommend to the governor a reduction of expenditures authorized by such appropriations, either direct or open-ended, for that fiscal year. The governor shall review the recommendations of the director and shall prepare his order containing reductions in expenditures authorized so that actual revenues for the fiscal period will be sufficient to equal the expenditures. The governor shall give not less than 5 days' written notice to the members of the appropriations committees of the house and senate specifying a time and place for a joint meeting of the governor and the 2 committees, at which the governor shall present to the committees his recommendations and copies of his proposed order.

Not later than 10 days after submission of the order to the committees, each committee by vote of a majority of its members elected and serving shall approve or disapprove the order. Approval of both appropriations committees is required before any expenditures authorized by appropriations shall be reduced. Upon approval by both appropriations committees, the director shall carry out and implement the order.

If either or both appropriations committees disapproves the order, the order is without force and effect. Not later than 30 days after any disapproval of a proposed order, the governor may give reasonable written notice to the members of the appropriations committees of the house and senate as to the time and place of a further joint meeting of the 2 committees at which time he shall resubmit an order reducing expenditures authorized by appropriations. Within 10 days of the receipt of the order by the appropriations committees, each committee shall by a majority of its members elected and serving, approve or disapprove the order. A copy of the order of the governor and resolutions of both the appropriations committees approving it shall be filed with the secretary of state and the order shall become effective.

Sec. 14. To implement executive order 1973-7, the department of mangement and budget shall assume the powers, fulfill the duties and perform the functions specified in section 5a of Act No. 51 of the Public Acts of the First Extra Session of 1948, being section 18.5a of the Michigan Compiled Laws.

Subject to the approval of the director of the department of management and budget, agencies with excess reserve data processing capacity are authorized to furnish data processing services beyond those authorized in this act. Such additional costs incurred to provide services are to be financed by charges made to requesting agencies.

Before exercising authority to approve the acquistion and use of electronic data processing equipment, including support services, communications, maintenance, and associated ancillary systems, it shall be the responsibility of the department of management and budget to assemble and submit for consideration of the joint computer and data processing subcommittee of the house and senate appropriations committees, the studies, planning data, proposal requests and procurement instruments related to such acquisition.

All the provisions contained herein are subject to review and approval or disapproval by the joint computer and data processing subcommittee of the house and senate appropriations committees.

Sec. 15. In addition to the appropriations for the fiscal year ending June 30, 1975, the legislature appropriates from the state funds contained herein to state agencies any amounts necessary to pay court judgments rendered under provisions of Act No. 236 of the Public Acts of 1961, as amended, being sections 600.6401 to 600.6475 of the Michigan Compiled Laws.

Sec. 16. The amounts appropriated in section 1 of this act for LEAA programs shall not revert to the general fund at the conclusion of the 1974-1975 fiscal year, but shall continue to be available for expenditure until the projects for which they were appropriated are completed or otherwise terminated. At the conclusion of the 1975-1976 fiscal year, the unencumbered balance for each completed or terminated project shall revert to the general fund and any unearned federal funds received for the completed or terminated project shall be returned.

Each department director having an appropriation for LEAA funds shall notify the director of the department of management and budget as to the June 30, 1975 status of each project for which LEAA appropriations have been made. This notification shall be made by the following August 1, and shall be in sufficient detail so that the director of the department of management and budget can cause the unencumbered balance of the completed or terminated projects to be reverted to the general fund.

Sec. 17. On January 30 and July 30 of each year, each department head shall submit a listing to the appropriations committees of the house of representatives and the senate with a copy submitted to the house and senate fiscal agencies, of every person who received compensation, fees, or remuneration of any type under the provisions of this act, for the preceding 6 months, of all travel outside the state. This listing shall include name, location, reason for and dates of travel and all transportation and related costs. The above listing shall be accompanied by a statement by the department head reflecting the total in-state travel for the same periods.

Sec. 18. When federal or state funds, appropriated in section 1 of this act are to be expended for any meeting (conference or seminar) that involved more than 10 state employees (collectively from 1 department) necessitating travel from their home counties, written notice to include the reason for the meeting (conference or seminar), duration, number of participants, location, time, date, total federal and/or state cost and the account from which the meeting (conference or seminar) will be financed shall be transmitted to the members of the senate and house appropriations committee not later than 15 days prior to the meeting date, with a copy submitted to the senate and house fiscal agencies.

Sec. 19. The amount appropriated in section 1 of this act for highway safety planning projects shall not revert to the general fund at the conclusion of the fiscal year but shall continue to be available for expenditures until the projects for which they are appropriated are completed or otherwise terminated.

Each department director having an appropriation for highway safety planning funds shall notify the director of the department of management and budget as to the June 30, 1975 status of each project for which highway safety planning appropriations have been made. This notification shall be made by the following August 1, and shall be in sufficient detail so that the director of the department of management and budget can cause the unencumbered balance of the completed or terminated projects to be reverted to the general fund.

Sec. 20. All moneys received as grants, subsidies, or in any form whatever from the federal government in payment of overhead expenses shall be deposited in a separate account which shall either lapse into the state general fund or be expended through the regular appropriating process.

Sec. 21. A recognized liability or delinquent billing for the fiscal year of 1973-74 only, for care of tuberculosis patients in excess of the appropriations for those purposes in the fiscal year 1973-74 may be paid from the appropriations made in this act.

Sec. 22. Expenditures against 1974-75 appropriations for medical care and treatment of crippled children, except for administration and operation, shall be based on billings received by the department of public health from July 1, 1974, through June 30, 1975. Statements of expenditures and financial reports should be prepared on this basis.

Sec. 23. Money appropriated herein for crippled children shall be paid in conformity with rules promulgated by the department of public health; such rules shall reflect federal terms and conditions as to provisions for payment of reasonable costs for hospitals and physician services.

Sec. 24. When tuberculosis care and treatment is provided on an outpatient basis approved by the health officer of jurisdiction where the patient resides or the state director of public health, the county providing such outpatient care and treatment shall be reimbursed for a portion of such cost from the same funds as are appropriated for the hospital subsidy; such reimbursement shall be in accordance with a formula adopted by the state director of public health.

Sec. 25. The director of public health shall promulgate rules to guide the development of experimental health care delivery centers such as health maintenance organizations, with particular emphasis upon defining services to be provided as well as the utilization of ancillary personnel such as physician assistants on a research and demonstration basis.

Sec. 26. Expenditures of state funds for family practice residencies shall be carried out under agreements developed by the director of pubulic health. Such agreements shall provide a formula for granting funds on the basis of subsidy per residency, provided that in 1974-75, not more than $750,000.00 shall be allotted for this purpose, and not less than 50 such residencies shall be developed utilizing funding from all sources, including this state assistance.

Sec. 27. From the appropriation of $300,000.00 for contractual residential services in section 2, the director of the department of social services may purchase specialized residential and community services from nonprofit organizations for the care of youth and young adults suffering from substance abuse.

Sec. 28. The director of the department of social services shall authorize payment for medical and health services provided under section 109 of Act No. 280 of the Public Acts of 1939, as amended, being section 400.109 of the Michigan Compiled Laws, for indigent persons medically diagnosed as suffering from alcohol or drug dependence who are otherwise eligible for medical and health services under sections 105 to 110 of Act No. 280 of the Public Acts of 1939, as amended, being sections 400.105 to 400.110 of the Michigan Compiled Laws.

Sec. 29. From the appropriation of $25,000.00 for evaluation of regional substance abuse education and prevention programs, the superintendent of public instruction shall provide for a detailed evaluation of the regional programs authorized during 1973-74 in cooperation with the administrator of the office of substance abuse services of the department of public health. The superintendent and the administrator shall report a summary of this evaluation to the governor and the legislature during November, 1974.

Sec. 30. It is the intent of the legislature that no later than October 1, 1974 the director of the department of public health shall submit to the senate and house appropriations committees, the house and senate fiscal agencies, and to the director of the office of health and medical affairs, a report which shall include, for each communicable disease specified by the director:

(1) What rates of disease incidence are thought by the director to be the optimum attainable in the CHASS area.

(2) What order of priority the director recommends for controlling or ameliorating the various communicable diseases occurring in the CHASS area.

(3) What target rates of communicable disease incidence are projected by the director for January 1, 1975, January 1, 1976, and for January 1, 1977.

(4) What dates the director projects as reasonable for the attainment of the optimum attainable incidence rates.

All data used by the director in arriving at his recommendations, together with his written analysis of these data, shall be a part of the report submitted.

Sec. 31. In order to promote more effective management of the department of public health, the director of the department may utilize up to 20 state positions from any appropriations account for functions in other state units which the director deems to be more critical to the management of departmental programs.

Sec. 32. The expenditure of the appropriation for the revision of the state's public health laws shall be under the control and direction of the legislative council.

Sec. 33. Any funds appropriated by this act or any funds received by the department from any source whatsoever, either governmental or private, which will be expended pursuant to any contractual agreements relative to contractual services of a study nature, shall be reported to the appropriations committees of the house and senate at least once each 6 months relative to the names of any person, company or association, the nature of the contract, the purpose of the contract study, the nature of the contract study being undertaken and the total cost of each study undertaken.

Sec. 34. There is appropriated $200,000.00 from the general fund of the state to the department of public health for the development and expansion of medical research relative to diabetes mellitus less any federal funds provided therefor.

Sec. 35. Each department shall report to the legislature annually the names, duties and compensation paid to all contractual employees.

This act is ordered to take immediate effect.

Beryl I. Kenyon
Secretary of the Senate.

Thos Thatcher
Clerk of the House of Representatives.

Approved ____________________

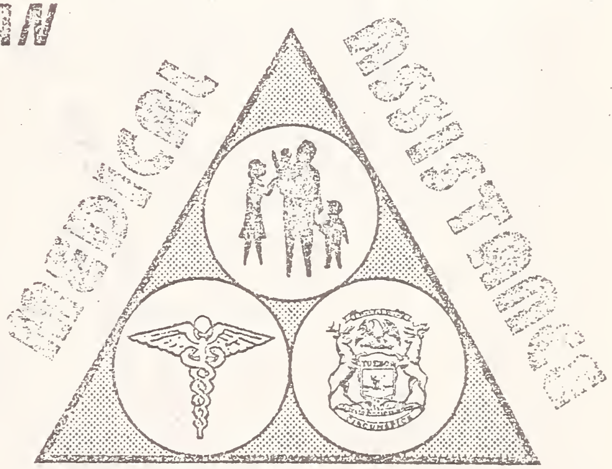
____
Governor.

Exhibit C

SECOND ANNUAL REPORT

RECEIVED
MAY 16 1975
EDMUND FERRARA
GOVERNMENT CLAIMS
ADMINISTRATION

STATE OF MICHIGAN

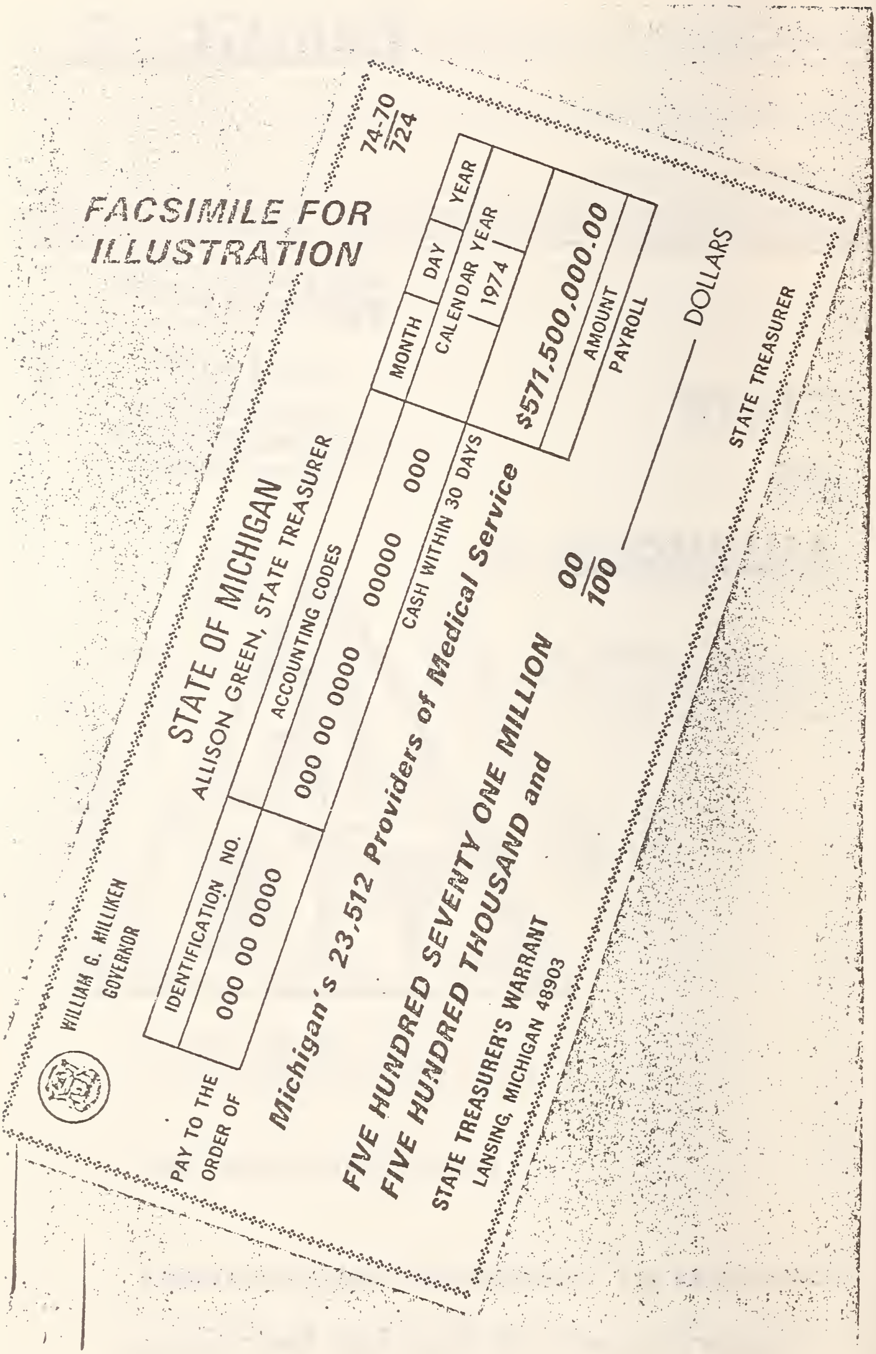


MEDICAL ASSISTANCE PROGRAM

CALENDAR YEAR 1974

Bureau of Medical Assistance
Department of Social Services

MARCH 1975



FACSIMILE FOR ILLUSTRATION

STATE OF MICHIGAN
ALLISON GREEN, STATE TREASURER

74-70
724

WILLIAM G. MILLIKEN
GOVERNOR

IDENTIFICATION NO.	ACCOUNTING CODES	MONTH	DAY	YEAR
000 00 0000	000 00 0000 00000 000	CALENDAR YEAR 1974		
	CASH WITHIN 30 DAYS	$571,500,000.00 AMOUNT PAYROLL		

PAY TO THE ORDER OF *Michigan's 23,512 Providers of Medical Service*

FIVE HUNDRED SEVENTY ONE MILLION FIVE HUNDRED THOUSAND and 00/100 DOLLARS

STATE TREASURER'S WARRANT
LANSING, MICHIGAN 48903

STATE TREASURER

INTRODUCTION

In the past year the Medicaid program in the State of Michigan has grown from annual expenditures of 436 million dollars to 571.5 million dollars. During this same time frame the number of recipients served by the program has grown approximately seven percent, from a total of 770,000 to slightly over 820,000 persons. The Michigan Medicaid program is one of the largest and most comprehensive programs in the United States. Within the total population served, approximately seventy percent of the recipients are children or persons over 65 years of age. As a general rule, those over 65 are also eligible for Medicare, and this group is increasing in size with advent of the Supplemental Security Income (SSI) program. In addition to children and the elderly, the program serves a significant number of disabled and blind adults.

Aside from inflation in medical prices, the major increase in medical expenses incurred during the past two years for the Medicaid population has been caused by the expansion of benefits to children under the Early & Periodic Screening, Diagnosis & Treatment (EPSDT) program. This program, which was launched in the Spring of 1973, has as its immediate objective the periodic medical screening of all eligible children in order that medical problems may be uncovered, diagnosed and treated at the earliest practicable time. A by-product of this effort is the major goal of providing needy persons access to the complete spectrum of health care services. Coincident with the establishment of EPSDT was the expansion of coverage for children to include dental services, vision services and hearing services. As a result, the Michigan Medicaid program is the largest third party system for dental services in the State. (See page 8 for distribution of expenditures).

The major thrust of the new Michigan Medicaid management systems introduced in 1972 and 1973 was to give all concerned better control over the financial and services delivery aspects of this burgeoning program, and to provide prompt and equitable reimbursement to all providers of medical services. The State believes quite strongly that most of these objectives have been achieved. The new system is now producing a wealth of management information with respect to the cost of services, the utilization of services, and the quantity of services provided to recipients. This information is current, extremely accurate and has proven to be most invaluable in program administration. With respect to the objective of providing prompt and equitable payment to providers, we believe that the Michigan program is the best in the nation. At the present time we are paying 83% of all bills received, regardless of source, within fifteen days; 97% of all billings are paid within thirty days. For example, in the area of physician billings we currently receive approximately 30,000 claims for service each day. As of the end of December 1974, there were less than 17,000 physician claims for service that had been in the system over thirty days. In the same vein, another significant statistic concerns hospitals. Accounts payable to hospitals as of the end of December 1974, were $2,000,000. This represents (an equivalent of) less than one week's worth of hospital billings, since the monthly Medicaid expenditure for hospital services is 17 million dollars. These results illustrate a prime feature of the new payment mechanism that allows management to quickly isolate and resolve day to day problems. In addition to the fast payment features, ancillary systems provide an abundance of utilization review data that is ideally suited for program management and data exchange under Professional Standards Review Organization concepts.

The State's high opinion of its new system is shared by the federal government and by the rest of the states and parts of Canada. State officials have been making presentations on the system in Lansing and nationwide to private and public agencies who wish to adapt the Michigan system to their own environment. Besides being efficient, the system is most economical. Total Medicaid costs approximate 36¢ per claim and are the lowest known administrative costs for this type operation.

The concept of future National Health Insurance is a bit murky at this time; whatever form it does take, however, a system such as the one we are currently using for the Michigan Medicaid program will be vital to the success of any expansion of third party payment mechanisms. Therefore, it is to the advantage of the Michigan medical community and to the State to ensure that what has been learned to date in this new approach to Medical Assistance administration is incorporated into future third party payment processes.

ELIGIBILITY

Individuals eligible for Medical Assistance benefits fall within two groups. The largest, the categorically needy, includes those persons who are receiving or are eligible for assistance under the Aid to Dependent Children and Supplemental Security Income (SSI) programs. The SSI program replaced the Old Age Assistance, Aid to the Partially and Totally Disabled and Aid to the Blind programs in January 1974, however, eligibility requirements are similar. The second group, the medically needy, is comprised of those persons who normally have adequate incomes, but incur medical expenses which reduce their income to a level necessitating assistance under one of the above programs. Medical Assistance benefits are, therefore, extended to this group in order to preserve their financial independence. Eligibility for this group generally results from chronic or catastrophic health problems. See page 4 for distribution by category of eligibility.

COVERAGES

Michigan's Medical Assistance program covers a wide range of services provided to eligible individuals, including:

Inpatient and Outpatient Hospitalization

Laboratory and Radiology

Physicians

Home Health

Pharmaceuticals

Ambulance

Dental Services (Children primarily)

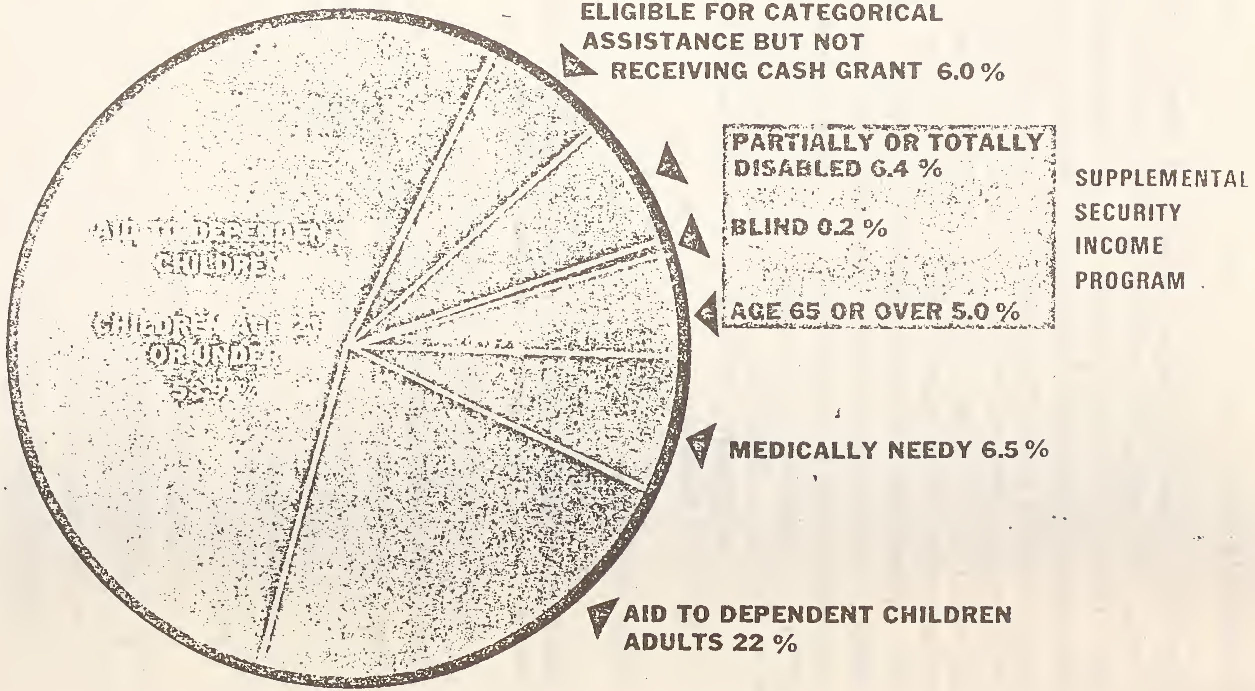
Family Planning Services

Limited Vision Services

Limited Psychiatric Services

Skilled and Basic Nursing Services

DISTRIBUTION OF INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS BY BA OF ELIGIBILITY



All such coverages are subject to certain limitations and utilization controls. In addition to the above, the Early and Periodic Screening, Diagnosis & Treatment program (Project Health), monitored and financed by the Department of Social Services in cooperation with the Michigan Department of Public Health, continues to provide health screening to children under age 21 in an effort to identify disease and abnormality and contribute to the health of such children. As of this date, about half of the 509,000 children eligible for such screening have been screened. This program was fully operational throughout 1974 and screened 133,500 children in this period. Seventy two thousand seven hundred or 54.5% of these children were then referred to participating Medical Assistance providers for further diagnosis and appropriate treatment. Cost of the screening aspects of this program during 1974 was $2,831,000 or $21.20 per screening.

SERVICES TO CRIPPLED CHILDREN

The Crippled Children program, administered by the Division of Services to Crippled Children (DSCC) of the Michigan Department of Public Health, provides care and treatment for eligible children who have handicapping or potentially handicapping conditions. Under an agreement between the Michigan Departments of Public Health and Social Services, DSCC utilizes the Department of Social Services as fiscal agent and utilizes the Medical Assistance payment mechanism for payment of services rendered to eligible crippled children recipients.

During 1974 the Crippled Children program served approximately 13,000 handicapped children in Michigan and made total expenditures of $11,750,000 for their care. An additional $49,000 was paid for treatment of 450 children (including those from states other than Michigan) at the Federal Area Child Amputee Center in Grand Rapids.

PROVIDER ENROLLMENT

The excellent cooperation of the medical community continued during 1974. Total enrollment rose from 21,720 in 1973 to 23,512 in 1974. (See Page 7)

PROVIDER RELATIONS

The Bureau continued its programs to maintain good working relationships with providers during 1974. The Inquiry Services and Seminar staffs were expanded to permit a more timely response to problem areas encountered by individual providers. During 1974 this staff responded to 76,000 verbal and written inquiries, held 240 seminars (an increase of over 100%) attended by 8,050 providers or their billing representatives, made 750 personal visits to providers, and distributed 17,950,000 billing invoices.

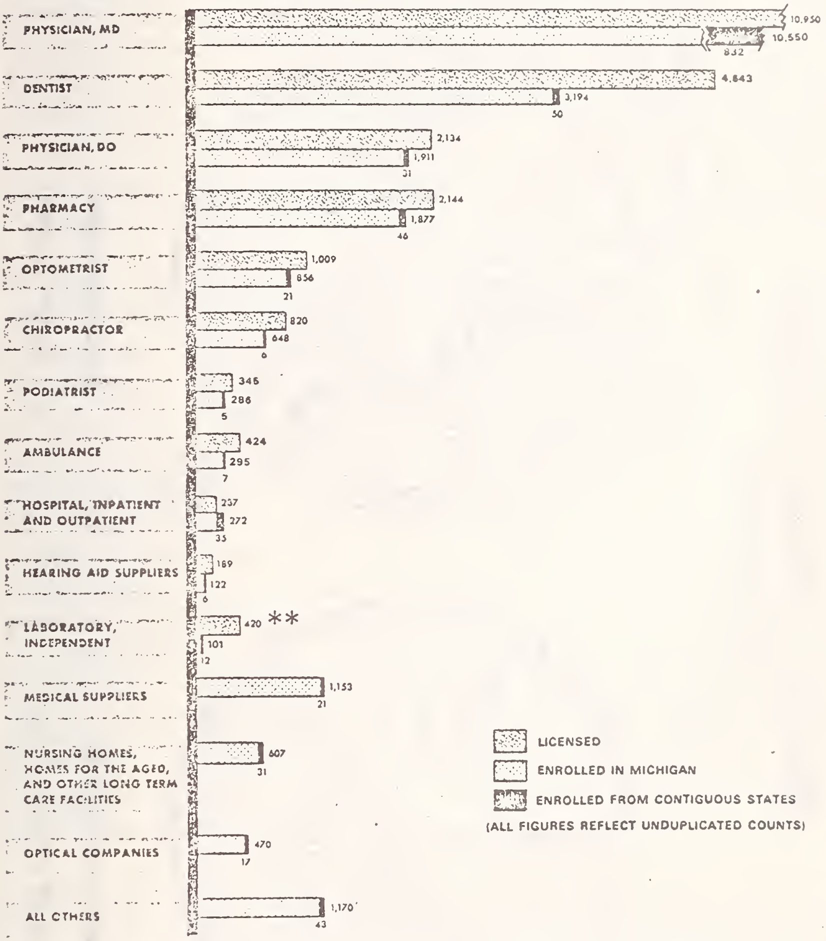
The Bureau is participating in projects with other major medical insurers in Michigan, and the Michigan State Medical Society and Hospital Financial Management Association to develop standardized claims forms for physicians and inpatient and outpatient hospital services. The standardized forms would allow physicians or hospitals to use one form for submission to any insurer in Michigan. This eliminates the need for providers to maintain stocks of forms for each insurer and reduces training and effort required to complete different forms for each insurer. As of this date, the standard physician billing form has reached the final approval stage.

FURTHER STATISTICS

During 1974 the Bureau received and processed 14,330,000 invoices representing over 29,000,000 individuals claims for payment. (See Page 8)

Although clients in the Aid to Dependent Children program represent the majority of those eligible for Medical Assistance benefits (nearly 76%, 53.9% children and 22% adults), they have the lowest per client health care costs. Elderly clients in long term care facilities, e.g., nursing homes, have the highest per client costs. The care of less than 35,000 such clients, with a median age of 82 years, accounts for more than 40% of total expenditures, (i.e., nursing home care, hospitalization, drugs and physician expenses, etc.) In combination, medical care for the blind, disabled, elderly and for children, constitutes over three-quarters of all Medical Assistance expenditures.

COMPARISON OF PROVIDERS ENROLLED IN MICHIGAN MEDICAID PROGRAM TO PROVIDERS LICENSED* IN MICHIGAN



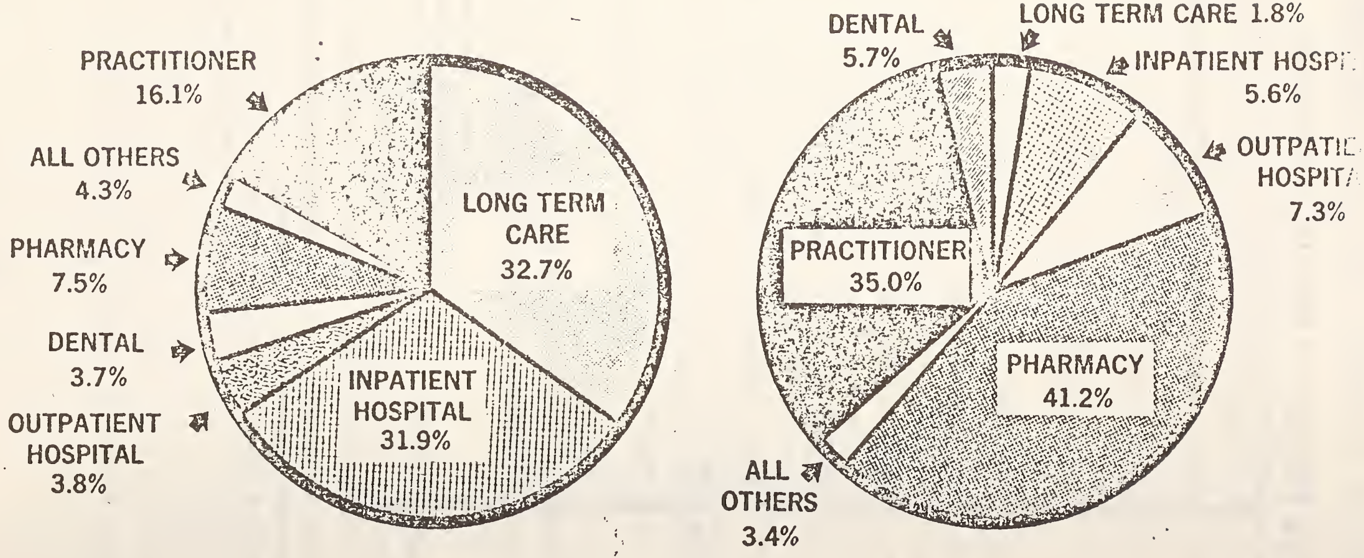
INCLUDES 40 FAMILY PLANNING AGENCIES, 50 HOME HEALTH AGENCIES, 110 DENTAL CLINICS, 200 MEDICAL CLINICS AND 770 PROVIDERS ENROLLED IN 12 OTHER CATEGORIES.

* *EXCLUDES THOSE LICENSED BUT NOT PRACTICING IN MICHIGAN*

** *INCLUDES LABORATORIES ASSOCIATED WITH OTHER MEDICAL FACILITIES, e.g. HOSPITALS*

MICHIGAN MEDICAID PROGRAM

CALENDAR YEAR 1974



$571.5 MILLION

DOLLAR EXPENDITURES

29.3 MILLION

CLAIM VOLUME

COST CONTAINMENT

The Michigan Social Welfare Act requires that Medical Assistance payments be made for services rendered to eligible individuals only after all other sources of payment are exhausted. In instances of payments made by Medical Assistance when other insurance coverage exists, the Bureau is required to recover the amount of funds expended for the care and treatment of the patient. The Third Party Liability section of the Bureau, in performing this function during 1974, investigated over 2,300 cases and made recoveries of $1,470,000.

The Post Payment Surveillance and Investigation Section of the Bureau of Medical Assistance verifies, through reviews of providers' billings, that claims submitted to the Medical Assistance program are valid and recovers funds paid in error, as a result of over-billing, or as a result of fraud or program abuse. In order to accomplish this, the section maintains a staff of professional investigators who conduct on-site reviews of billings and supporting documentation and interview recipients of Medical Assistance benefits to determine compliance with program rules and regulations. The section also completes profiles and analyses of claims in cases of suspected over-utilization or other program abuse and develops case studies which may lead to refund, removal from program participation, or criminal prosecution. During 1974 this section finalized investigation of 121 cases resulting in recoveries of $1,018,770. An additional 300 cases were open and under active investigation at the end of 1974. In addition to actual recoveries an estimated $550,000 in improper payments were prevented by the section's activities.

Actions are underway to increase the effectiveness and returns of both of these areas. Existing efforts are returning five dollars to the program for every one dollar of administrative expense.

The Bureau in May, 1974, created a new division, the Cost, Audit and Rate Setting Division, in order to improve its effectiveness in the financial auditing area by maximizing audit capability under central control. This new division has been working with Michigan Medical Services under a common audit agreement, expediting final settlement of a large backlog of pending audits accumulated since

1966. As a result, a point has been reached at which cost settled providers may now expect initial and final settlements within eighteen months of the end of their fiscal year. This reorganization also allowed more frequent, limited, nursing home audit reviews which have revealed improper billings and related procedures resulting in potential recoveries for the Medicaid program and for recipients in excess of $1,000,000.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

As a step toward assuring quality health care delivery, the Department of Health, Education and Welfare and the medical community developed the Professional Standards Review Organization (PSRO) concept. PSROs are being organized for operation by local medical professionals in each of ten regional areas in Michigan. Each PSRO will review and evaluate hospital, nursing home and physician services in their area for appropriateness of treatment and medical necessity. Through this activity, PSROs will seek to improve quality of care and to prevent overutilization or improper utilization of services by patients and providers.

The Bureau of Medical Assistance and the Michigan Department of Public Health are cooperating with each PSRO in Michigan as it is organized in order to establish working relationships. This will include exchange of statistical health care data, particularly that pertinent to the Medicaid population, and allow the identification of utilization problems and health care delivery problems without duplication of effort and expense.

HEALTH MAINTENANCE ORGANIZATION

The Health Maintenance Organization (HMO) is a relatively new concept in health care delivery. HMOs are privately organized corporations which contract with individuals, or in the case of the voluntarily enrolled Medical Assistance client, with the State, to provide all necessary medical services to the enrollee for a fixed fee per month. This fixed fee system, as opposed to a fee for service system, provides incentive for the HMO to utilize the fewest services and resources consonant with its responsibility for maintaining the health of its enrollees. To accomplish this goal the HMO provides periodic medical examinations for early detection of health problems and easy access to treatment before a condition worsens. By bringing together, within a single organization, the physician, hospital, laboratory and clinic the HMO seeks to maintain a healthier population through preventive health care and treatment of the whole person. The HMO concept is an attractive option to the Medicaid population because it provides a much needed continuing provider-patient relationship.

The Bureau of Medical Assistance extended contracts with three HMOs in Michigan (two in metropolitan Detroit and one in the Benton Harbor area) during 1974. These HMOs had enrolled nearly 40,000 Medical Assistance clients at the end of 1974. Total Medicaid payments to HMOs during 1974 were $7,756,500.

The Medical Assistance program is cooperating with several developing HMOs in Michigan and is evaluating health care benefits as well as examining HMO costs in relation to Medicaid experience under the conventional fee for service basis.

ADMINISTRATIVE COSTS

Because of continuing improvements in the processing of claims, the Bureau's total cost per claim increased only 2.8% to 36¢ per claim line in 1974; a modest increase considering inflationary trends in other areas. The major causes for this increase apart from general inflationary increases in labor and materials were expansion of overhead costs associated with utilization review and audit functions.(See Pages 13 and 14.

MANAGEMENT AND ADMINISTRATIVE REPORTING SYSTEM

In order to maintain and improve its present efficiency the Bureau completed development and began implementation of the Management and Administrative Reporting System (MARS). MARS, a federally sponsored system, will provide additional detailed information for all levels of management, allowing more accurate assessment of problem areas and speedier resolution.

Reports generated by this system are geared to the following areas:

Administration:	Program policy review and determination
Budget:	Trend analysis and liability projection
Operations:	Cost settlement, audit and rate setting information.
	Third party liability and collection information
	Invoice processing performance
	Provider and recipient profiling
Provider Relations:	Identification of distribution of enrolled providers allowing increased efforts to encourage enrollment in areas lacking access to a specific service.
	Identification of specific individual billing problems permitting corrective assistance and prevention of payment delays.

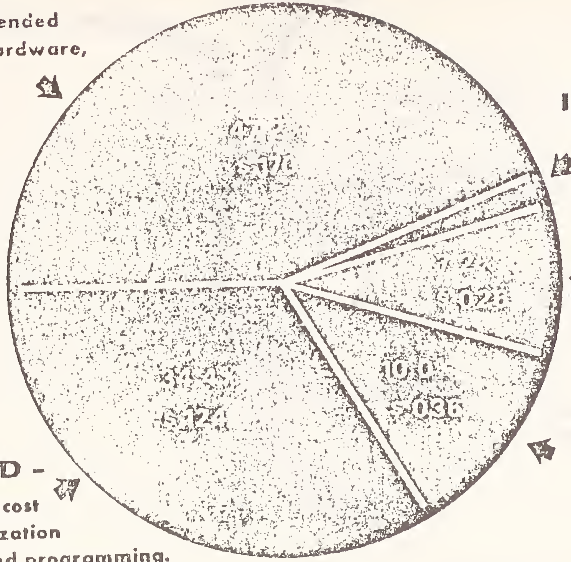
SUMMARY - 1974

In summary, 1974 was another year of significant progress for the Michigan Medical Assistance Program.

- More clients than ever were given access to quality health care.
- Expanded health benefits, particularly in the area of preventative treatment, were extended to children.
- Provider relations achieved a new peak of mutual accord and program participation.
- Business volume was up and administrative costs were contained.

Unfortunately, because of rapidly escalating health care costs and the condition of the State and National economies, 1975 will be a most difficult year for the Medical Assistance program. As unemployment increases, so does Medicaid program activity. On the other hand, state revenues supporting public programs are concurrently decreasing as the cost of services rise. For all of these reasons you may

MICHIGAN MEDICAID
CLAIMS PROCESSING COSTS
1974



PAPER PROCESSING -
includes handling, mailing, pended claims, EDP operations and hardware, and warrants

INDIRECT OVERHEAD -
personnel, accounting and business services support 1.2% $.004

OTHER COST-
regulation and review, post payment audit, dental and special services prior authorization.

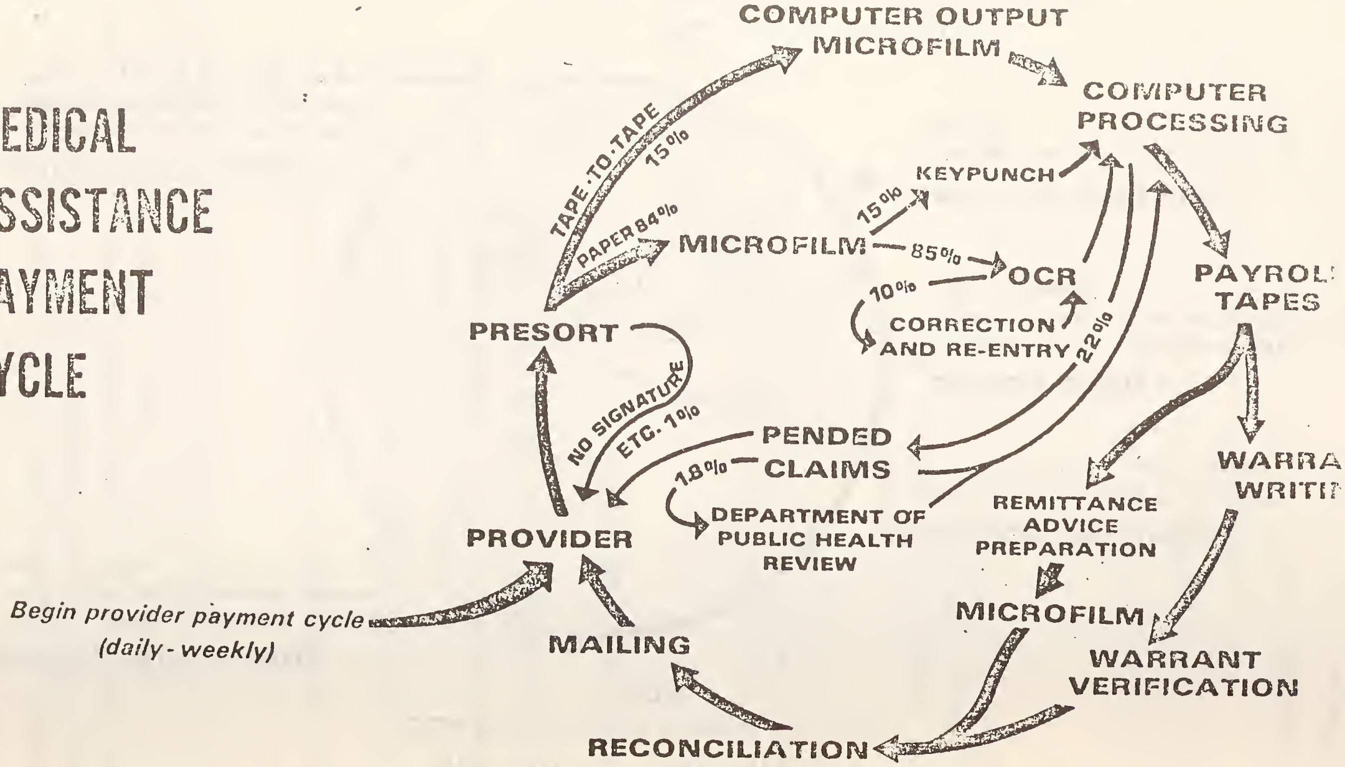
ADMINISTRATION -
directors and staffs, policy and planning

DIRECT OVERHEAD -
includes provider relations, cost settlement and control, utilization review, systems analysis and programming.

TOTAL = $0.36 PER CLAIM

The typical invoice containing 2.0 claim lines is processed and paid for $0.72

MEDICAL ASSISTANCE PAYMENT CYCLE



expect a significant tightening of program guidelines in an effort to contain costs without reducing fees or services essential to the Medicaid population. Your cooperation and understanding is solicited as we move forward in our cost containment program.

MEDICAID PROGRAM CHARACTERISTICS

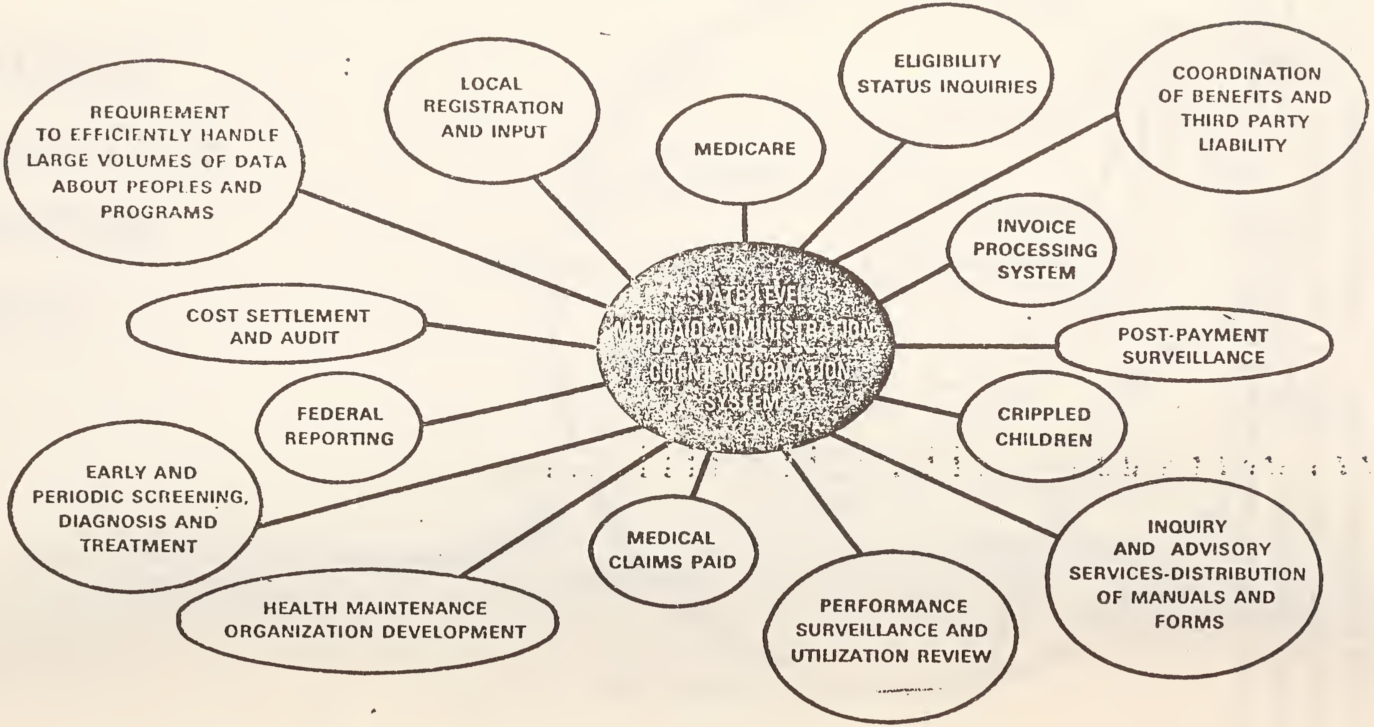

STATE LEVEL MEDICAID ADMINISTRATION CLIENT INFORMATION SYSTEM
REQUIREMENT TO EFFICIENTLY HANDLE LARGE VOLUMES OF DATA ABOUT PEOPLES AND PROGRAMS
LOCAL REGISTRATION AND INPUT
MEDICARE
ELIGIBILITY STATUS INQUIRIES
COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY
INVOICE PROCESSING SYSTEM
POST-PAYMENT SURVEILLANCE
CRIPPLED CHILDREN
INQUIRY AND ADVISORY SERVICES-DISTRIBUTION OF MANUALS AND FORMS
PERFORMANCE SURVEILLANCE AND UTILIZATION REVIEW
MEDICAL CLAIMS PAID
HEALTH MAINTENANCE ORGANIZATION DEVELOPMENT
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
FEDERAL REPORTING
COST SETTLEMENT AND AUDIT

EXHIBIT D

FISCAL YEAR 1974 MEDICAL ASSISTANCE EXPENDITURES

States	Administrative expenditures (1)	Benefit expenditures (2)	Column (1)÷(2) (percent)
Alabama	$4,532,612	$104,329,738	4.34
Alaska	488,019	6,869,285	7.10
Arizona			
Arkansas	1,314,867	69,058,570	1.90
California	89,272,488	1,277,526,976	6.99
Colorado	4,356,618	80,803,894	5.39
Connecticut	4,609,136	130,446,896	3.53
Delaware	650,956	13,059,897	4.98
Washington, D.C	4,423,447	70,580,720	6.27
Florida	6,108,525	115,770,763	5.28
Georgia	4,369,179	182,529,811	2.39
Guam	21,952	1,059,070	2.07
Hawaii	1,579,346	29,047,565	5.44
Idaho	578,406	17,673,507	3.27
Illinois	22,725,791	656,533,668	3.46
Indiana	5,583,974	137,406,357	4.06
Iowa	3,455,573	59,876,892	5.77
Kansas	3,850,584	73,694,314	5.23
Kentucky	3,984,603	84,930,924	4.69
Louisiana	2,833,821	104,044,570	2.72
Maine	1,479,717	51,137,239	2.89
Maryland	9,386,479	167,623,857	5.60
Massachusetts	16,921,272	475,590,487	3.56
Michigan	22,560,613	517,714,852	4.36
Minnesota	7,020,652	233,060,927	3.01
Mississippi	4,614,096	85,280,747	5.41
Missouri	2,207,101	74,877,609	2.95
Montana	1,266,222	20,469,137	6.19
Nebraska	3,071,557	48,913,663	6.28
Nevada	1,305,985	12,768,631	10.23
New Hampshire	1,515,894	22,688,641	6.68
New Jersey	12,459,821	298,170,739	4.18
New Mexico	2,012,550	26,843,219	7.50
New York	78,761,987	2,189,537,657	3.60
North Carolina	6,552,640	124,923,599	5.25
North Dakota	956,632	17,099,703	5.59
Ohio	11,609,422	301,170,861	3.85
Oklahoma	5,361,393	130,304,316	4.11
Oregon	4,292,409	57,227,531	7.49
Pennsylvania	15,285,631	328,823,483	4.65
Puerto Rico	5,056,999	69,139,492	7.31
Rhode Island	2,031,715	58,715,252	3.46
South Carolina	1,704,396	57,816,090	2.95
South Dakota	1,116,251	16,581,149	6.73
Tennessee	3,757,167	91,622,078	4.10
Texas	17,141,374	398,521,802	4.40
Utah	1,846,075	30,956,874	5.96
Vermont	1,371,204	28,270,197	4.85
Virginia	7,842,178	129,748,548	6.04
Virgin Islands	274,473	1,404,777	19.54
Washington	7,445,073	128,769,896	5.78
West Virginia	1,293,377	30,091,335	4.30
Wisconsin	7,385,943	246,922,686	2.99
Wyoming	260,570	4,367,330	5.97

SUMMARY OF STATE EXPENDITURES FOR MEDICAL ASSISTANCE PROGRAM MEDICAL ASSISTANCE PAYMENTS (INCLUDING INTERMEDIATE CARE FACILITY SERVICES)—FISCAL YEAR 1974

[Accounts in dollars]

State	Total payments including payments not computable for Federal funding	Total payments computable for Federal funding	Unadjusted Federal share	Collections	Adjustments	Adjusted Federal share	Local funds
Total	$10, 503, 008, 214	$9, 737, 397, 821	$5, 365, 698, 472	−$14, 530, 976	−$212, 296, 494	$5, 563, 463, 990	$812, 593, 188
Alabama	104, 773, 109	104, 329, 738	79, 407, 783		−2, 619, 352	76, 788, 431	
Alaska	6, 869, 285	6, 869, 285	3, 434, 641			3, 434, 642	
Arizona							
Arkansas	69, 384, 757	69, 058, 570	52, 710, 775		3, 481	52, 714, 256	
California	1, 581, 894, 073	1, 277, 526, 976	655, 185, 873		66, 360, 203	721, 546, 076	203, 893, 098
Colorado	80, 961, 725	80, 803, 894	46, 328, 967	−27, 336	−294, 504	46, 007, 127	
Connecticut	131, 349, 970	130, 446, 896	65, 225, 866	−600, 611	−25, 590	64, 599, 665	
Delaware	13, 059, 896	13, 059, 897	6, 529, 949		−257, 881	6, 272, 069	
District of Columbia	71, 145, 260	70, 580, 720	35, 290, 360		60, 592	35, 350, 952	564, 540
Florida	116, 636, 009	115, 770, 763	70, 562, 832		−1, 447, 532	69, 115, 300	
Georgia	184, 239, 372	182, 529, 811	122, 329, 884		−1, 673, 081	120, 656, 803	
Guam	1, 067, 906	1, 059, 070	529, 534			529, 534	6, 315
Hawaii	34, 412, 286	29, 047, 565	14, 658, 426	−30, 759	1, 425, 466	16, 053, 133	
Idaho	17, 835, 611	17, 673, 507	12, 283, 088	−5, 115	−3, 441	12, 274, 532	
Illinois	662, 045, 213	656, 533, 668	328, 266, 835	−2, 918, 948	−507, 686	324, 840, 201	
Indiana	138, 601, 663	137, 406, 357	78, 335, 364	−541, 205	−894	77, 793, 265	2, 188
Iowa	60, 640, 041	59, 876, 892	35, 924, 156	−577, 978	41, 802	35, 387, 980	
Kansas	81, 900, 518	73, 694, 314	40, 836, 148	−55, 705	−39, 225	40, 741, 218	9, 385, 844
Kentucky	85, 133, 086	84, 930, 924	61, 325, 639	−1, 325, 916	2, 700, 093	62, 699, 816	
Louisiana	104, 656, 394	104, 044, 570	75, 744, 533		6, 571, 972	82, 316, 504	312, 567
Maine	51, 137, 239	51, 137, 239	35, 899, 173	−3, 075		35, 896, 098	

Maryland	202, 367, 721	167, 623, 857	84, 390, 294	−191, 597	1, 941, 511	86, 140, 208	10, 976, 612
Massachusetts	475, 739, 506	475, 590, 487	237, 834, 152	−2, 692, 884	−3, 649	235, 137, 619	
Michigan	578, 605, 159	517, 714, 852	259, 871, 554	−445	8, 219, 954	268, 091, 063	
Minnesota	236, 563, 405	233, 060, 927	133, 770, 852	−3, 533	457, 018	134, 224, 337	53, 828, 221
Mississippi	85, 523, 358	85, 280, 747	68, 729, 831	−358, 803	2, 376	68, 373, 404	
Missouri	81, 723, 702	74, 877, 609	44, 992, 253	−71, 645	4, 367	44, 924, 974	
Montana	20, 728, 284	20, 469, 137	13, 543, 771	−67, 674	−6, 000	13, 470, 097	3, 666
Nebraska	48, 914, 773	48, 913, 663	28, 322, 339		−866, 546	27, 455, 793	6, 137, 417
Nevada	14, 375, 312	12, 768, 631	6, 384, 314			6, 384, 314	1, 812, 073
New Hampshire	22, 919, 588	22, 688, 641	14, 078, 301	−5, 542	−71, 425	14, 001, 334	10, 271
New Jersey	319, 226, 743	298, 170, 739	149, 772, 520	−2, 221, 648	6, 418, 493	153, 969, 365	
New Mexico	26, 430, 568	26, 843, 219	19, 342, 843		25, 682	19, 368, 525	
New York	2, 300, 012, 590	2, 189, 537, 657	1, 096, 720, 705	−1, 727, 217	56, 808, 749	1, 151, 802, 237	487, 360, 731
North Carolina	128, 064, 926	124, 923, 599	87, 607, 610		9, 517, 840	97, 125, 450	5, 826, 080
North Dakota	17, 107, 240	17, 099, 703	11, 995, 492	−112, 032	−337, 931	11, 545, 529	701, 483
Ohio	304, 039, 666	301, 170, 861	161, 397, 465	−303, 293	2, 560, 851	163, 655, 023	
Oklahoma	130, 489, 823	130, 304, 316	88, 769, 061		−2, 122, 302	86, 646, 759	
Oregon	60, 348, 446	57, 227, 531	34, 152, 640	−4, 912	1, 190, 789	35, 338, 517	31, 419
Pennsylvania	541, 715, 863	382, 823, 483	211, 298, 718	−145, 590	50, 174, 516	261, 327, 644	
Puerto Rico	100, 295, 173	69, 139, 492	27, 507, 835			27, 507, 835	29, 246, 550
Rhode Island	62, 670, 144	58, 715, 252	32, 732, 600	−24, 685	2, 153, 160	34, 861, 075	
South Carolina	57, 816, 090	57, 816, 090	43, 377, 013		374, 031	43, 751, 044	
South Dakota	17, 219, 663	16, 581, 149	11, 648, 256			11, 648, 256	
Tennessee	91, 956, 776	91, 622, 078	66, 224, 437		−200, 570	66, 023, 867	
Texas	391, 551, 101	389, 521, 802	248, 018, 054		−74, 064	247, 943, 990	
Utah	31, 206, 377	30, 956, 874	21, 654, 332	−12, 841	−109, 631	21, 531, 860	375, 062
Vermont	28, 270, 197	28, 270, 197	18, 483, 053	−401	236, 708	18, 719, 360	
Virginia	132, 481, 113	129, 748, 548	79, 899, 154		5, 722, 175	85, 621, 329	
Virgin Islands	2, 230, 788	1, 404, 777	702, 388			702, 388	1, 352, 816
Washington	111, 971, 163	128, 769, 896	68, 469, 369	−482, 108		67, 987, 261	
West Virginia	31, 396, 100	30, 091, 335	22, 123, 148	−17, 478		22, 105, 670	
Wisconsin	246, 922, 686	246, 922, 686	148, 404, 717		−30, 672	148, 374, 045	
Wyoming	4, 380, 757	4, 367, 330	2, 669, 575		16, 641	2, 686, 216	766, 235

STATE AND LOCAL ADMINISTRATION FOR MEDICAL ASSISTANCE—FISCAL YEAR 1974

[Amounts in dollars]

State	Total payments computable for Federal funding	Total Federal share	Total payments from local funds
Total	$431, 908, 765	$236, 148, 113	$24, 492, 141
Alabama	4, 532, 612	2, 658, 026	
Alaska	488, 019	256, 096	
Arizona			
Arkansas	1, 314, 867	895, 147	
California	89, 272, 488	46, 636, 244	
Colorado	4, 356, 618	4, 432, 643	134, 570
Connecticut	4, 609, 136	2, 503, 090	
Delaware	650, 956	329, 280	
District of Columbia	4, 423, 447	2, 237, 992	2, 185, 455
Florida	6, 108, 525	3, 277, 714	
Georgia	4, 369, 179	2, 421, 396	
Guam	21, 952	10, 976	
Hawaii	1, 579, 346	878, 944	
Idaho	578, 406	331, 921	
Illinois	22, 725, 791	12, 238, 791	
Indiana	5, 583, 974	2, 898, 102	112, 131
Iowa	3, 455, 573	1, 839, 722	
Kansas	3, 850, 584	2, 025, 046	161, 099
Kentucky	3, 984, 603	2, 214, 620	
Louisiana	2, 833, 821	1, 642, 821	28
Maine	1, 479, 717	891, 118	
Maryland	9, 386, 479	5, 062, 950	
Massachusetts	16, 921, 272	8, 873, 254	
Michigan	22, 560, 613	11, 896, 576	
Minnesota	7, 020, 552	3, 720, 044	3, 670, 930
Mississippi	4, 614, 096	2, 447, 023	
Missouri	2, 207, 101	1, 228, 902	
Montana	1, 266, 222	799, 264	
Nebraska	3, 071, 557	1, 650, 885	
Nevada	1, 305, 985	710, 935	
New Hampshire	1, 515, 894	845, 814	
New Jersey	12, 459, 821	7, 233, 010	
New Mexico	2, 012, 550	1, 180, 125	
New York	78, 761, 987	42, 149, 534	17, 175, 033
North Carolina	6, 552, 640	3, 377, 899	614, 711
North Dakota	956, 632	583, 192	154, 354
Ohio	11, 609, 422	6, 086, 015	240, 529
Oklahoma	5, 361, 393	2, 985, 854	
Oregon	4, 292, 409	2, 578, 178	15, 183
Pennsylvania	15, 285, 631	9, 534, 935	15, 907
Puerto Rico	5, 056, 999	2, 492, 162	
Rhode Island	2, 031, 715	1, 158, 429	
South Carolina	1, 704, 396	965, 270	
South Dakota	1, 116, 251	598, 598	
Tennessee	3, 757, 167	1, 945, 110	
Texas	17, 141, 374	12, 059, 291	12, 211
Utah	1, 846, 075	1, 087, 417	
Vermont	1, 371, 204	766, 832	
Virginia	7, 842, 178	4, 253, 234	
Virgin Islands	274, 473	159, 816	
Washington	7, 445, 073	4, 323, 150	
West Virginia	1, 293, 377	779, 132	
Wisconsin	7, 385, 943	3, 809, 187	
Wyoming	260, 570	186, 407	

EXHIBIT E

BLUE SHIELD OF MICHIGAN AND MEDICAID

	1971	1972
Medicaid eligibles, December 31	732,200	831,800
Claims receipts:		
Medical	1,974,538	2,405,600
Drugs	2,823,960	1,874,400
Medicare/medicaid combined	411,516	378,318
Total	5,210,014	4,658,318
Paid services [1]:		
Medical	4,889,747	5,013,238
Drugs	5,061,385	3,854,916
Total	9,951,132	8,868,154
Benefits paid:		
Medical	$45,345,262	$52,236,982
Drugs	19,230,730	14,648,681
Total	64,575,992	66,885,663
Program savings:		
Prepayment screens	4,517,883	5,009,365
Customary and prevailing charge reductions	3,700,000	6,249,000
Post payment audit	1,037,668	[2] 179,988
Total savings	9,255,551	11,438,353
Administrative costs:		
Total administrative	3,797,434	3,253,642
Benefit cost/service	6.49	7.82
Administrative cost/paid service	.38	.37

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[1] A service is a procedure performed by the provider. A claim could contain several services.

[2] Post payment audit function was turned over to the State May 1, 1972.

EXHIBIT F

BLUE CROSS OF MICHIGAN MEDICAID STATISTICS

	1971	1972
Claims receipts:		
Inpatient	226,456	257,612
Outpatient	543,017	717,738
Home health	5,648	5,905
Total	775,121	981,255
Paid cases:		
Inpatient	158,025	172,382
Outpatient	444,308	571,382
Home health	4,608	5,479
Total	606,941	749,243
Benefits paid:		
Inpatient	$102,493,546	$130,460,369
Outpatient	9,178,933	13,859,685
Home health	344,302	404,922
Total	112,016,781	144,724,976
Program savings (medical review):		
Inpatient	1,310,172	[1] 4,228,290
Outpatient	180,344	213,772
Administrative costs:		
Unaudited costs	1,404,490	1,863,563
Cost per invoice received	1.81	1.90
Percent of benefit dollars	1.25	1.29

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[1] Includes 710 rejected psychiatric claims at Wayne County General amounting to $2,559,444.

EXHIBIT G

MEDICAID AND MICHIGAN BLUE SHIELD: POSTPAYMENT AUDITS

In addition to payment controls, routine followup or postpayment audits of provider records on site are necessary to assure that adequate measures have been taken to avoid unnecessary payments.

These audits are the responsibility of the 58-member service review department. Personnel includes senior service analysts who investigate cases of major importance, analysts who perform routine audits and conclude cases of a less serious nature, and clerical and research people. One fulltime consulting physician is available to accompany field personnel on investigative trips.

Activities conducted by service review in 1971:

—1,615 routine audits of hospitals, extended care facilities, pharmacies, ambulance companies, laboratories, chiropractors, and clinics.

—328 special studies were done with providers that had unusually large or significantly changed incomes, including 96 providers whose incomes exceed $25,000.

—2,998 physicians and 78 chiropractors were reviewed during the course of routine institutional audits.

—3,130 formal audits were conducted, with 2,005 cases closed; 1,374 cases showed no basis for further investigation; 1,621 indicated grounds for recovering payments.

—Recoveries of medicaid money totaled $1,037,668.89; $873,233 of that amount came from one hospital which had billed the program incorrectly.

The principal techniques used by the service review department in postpayment screening of claims include the following:

Audits.—Random samples of claims paid to individual providers of a cross section of services are scanned routinely. This is a proven casefinding technique which enables analysts to detect incorrect billing and reporting.

Investigation.—Analysts investigate complaints from medicaid recipients and cases referred from other Blue Shield and/or Blue Cross departments.

Utilization Profiles.—Patient and physician profiles reveal patterns of practice for individual providers. Profiles may be used for comparing one physician with others in the same specialty and geographical area. They are essential for special studies of irregular billing.

Special Studies.— Service analysts periodically review claims of providers who (a) appear to have excessively high incomes, (b) have substantially increased their incomes over the previous year, or (c) seem to show high utilization of relatively few procedures codes.

Physician Review.—Because of the vast number of private office practices in Michigan, the routine office audit is impractical as a postpayment review procedure. Blue Shield therefore reviews physician's billing and reporting activities at the same time it audits institutions with which they are associated. Core element of the review process is computer screening on the basis of income, frequency of utilization, and charge reporting in the institutional setting.

EXHIBIT H

REVIEW OF ACTIVITIES, 1972–73

ROUTINE ACTIVITY

Throughout the 16 months since the last Blue Cross report on medicaid, the intermediary functions described in the introduction were continued as usual. Itemized descriptions of these activities may be found in previous reports; following are synoptic summaries.

The processing of bills involved counting and sorting, computer coding, edit review for eligibility, and final review to prevent duplicate payments. Vouchers were then prepared for each provider, and appropriated fund requests were sent to MDSS.

The computer edit program automatically pulled bills for investigation when eligibility files did not correspond to data submitted by the provider. This additional review procedure reduced the number of returned bills and facilitated cash flow to providers.

Average processing time was steadily reduced, and at the time of phase-out stood at 10 calendar days for valid claims.

Medical review was performed by registered nurses in the Blue Cross Medical Department, with occasional guidance on questionable cases from physician case consultants. This surveillance of bills was based on medical analysis, comparison of diagnosis, ancillary charges, age of patient, and length of stay.

As noted in the statistical section, savings to the State through this procedure were very significant in 1972—an all-time high of $4,228,290. In addition to serving as a deterrent to overutilization, the medical review process is an incentive to providers to closely examine bills (before submission) for any inappropriate charges.

The provider relations area continued to provide on-site servicing through representatives, who visited medicaid providers on a scheduled basis.

Appendix 6

LETTER AND ENCLOSURE FROM PAUL M. ALLEN;* TO VAL HALAMANDARIS, ASSOCIATE COUNSEL, SENATE SPECIAL COMMITTEE ON AGING, DATED MAY 5, 1976

DEAR MR. HALAMANDARIS: Thank you for the opportunity to comment on the November 20, 1975, statement prepared by Michigan Blue Cross and Blue Shield regarding my testimony of September 26, 1975, on Michigan's program to deter abuse and fraud in the medical assistance program.

The controversy over the relative efficiencies of public sector versus private sector program management is ongoing. In many cases, the comparison and the conclusion to be drawn is not easy to objectively quantify. However, we feel that in Michigan's case it is possible to demonstrate relative cost effectiveness.

Administrative costs as applied to the medical assistance program encompass all costs involved in operating and managing the program, At issue in the current controversy are those costs attributable to fiscal intermediary functions. Fiscal intermediary functions, as we knew them in our previous relationship with Blue Cross and Blue Shield, are those involving the actual processing and payment of bills received for services rendered under the program. Other costs are incurred by the State in addition to fiscal intermediary costs regardless of who performs the fiscal intermediary function. Among these costs are those incurred for eligibility determination, long-term care evaluation, utilization review, rate setting, policy, and planning and regulatory functions.

If a comparison is to be made, therefore, between the performance of Blue Cross/Blue Shield and the State, it must be between those functions previously performed by Blue Cross/Blue Shield and those similar functions as now performed by the State. When total administrative costs are broken down on this basis and projected for the full fiscal year (July 1, 1975 through June 30, 1976), costs for functions directly comparable to those previously performed by Blue Cross/Blue Shield total $0.26 per claim processed. (See attached cost analysis.) This equates to slightly less than 1.1 percent of total benefit payments for this fiscal year. A similar cost ratio was evident in fiscal year 1975. Projections for fiscal year 1977, again for comparable functions, indicate total expenditures for this portion of administration of $9.5 million against estimated benefit payments of $835 million, a ratio of 1.14 percent. These current ratios compare to administrative costs incurred by Blue Cross/Blue Shield in 1971, as reported by them in their statement, of 2.95 percent of benefit payments. Further, I understand their current ratio for private business approximates 5 percent of benefit payments.

At this point, I would like to mention that the fiscal intermediary functions for the Medi-Cal program in California (California's medicaid program) are performed under contract by California Blue Cross/Blue Shield at a cost of $0.91 per claim processed. This is comparable to the per claim cost or $0.26 discussed above. This $0.91 per claim is exclusive of additional administrative costs incurred by the State of California for non-Blue Cross/Blue Shield functions involving approximately 575 State employees.

I would also like to comment on the data presented by Blue Cross/Blue Shield in their statement which purports to represent administrative costs incurred by the State. As indicated, the comparisons made throughout this section are confused by costs for Blue Cross/Blue Shield comparable functions and those costs incurred by the State regardless of who performs the fiscal agent functions. There are, however, additional misunderstandings of these data which further distort the comparison.

> Item 1 compares appropriated costs for two administrative appropriation units to appropriated amounts for benefit payments. The administrative costs presented here do not represent total costs and include some non-Blue Cross/Blue Shield functions. More importantly, however, these figures do not represent final expenditures for the period indicated. Administrative costs actually expended for the two appropriation units cited, for example, totaled $7.5 million compared to an appropriated $8.7 million whereas total benefit payments, including supplemental appropriations, were $615.9 million, rather than the $588.9 million cited.
>
> Items 2 and 3, once again, involve costs in addition to an intermediary's comparable functions. Item 3, in particular, includes costs for eligibility determination including a component of operations of the department's county offices. As such, these ongoing costs have no relationship to who is the medicaid intermediary.

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*See statement, p. 9.

The costs cited by the State include those identifiable functions performed by State agencies other than the department of social services. Cost data have in the past been subjected to review by the State auditor general and were found to be substantially accurate.

When comparability of functions is carefully considered to avoid confusion over the various costs involved in administering the State's medicaid program, we stand on the record that the State has markedly reduced costs and increased operating efficiencies.

When all factors are considered and fully understood and costs properly compared, my statement that the State's administrative costs are only slightly more than 1 percent of benefit payments is fully supported, and fully documentable.

The portion of my testimony on Michigan's programs to curb program abuse and fraud dealt primarily with the investigative unit of the bureau of medical assistance. This unit and the systems and procedures utilized by it were developed independently of those utilized by Blue Cross/Blue Shield. The emphasis in this particular unit is on intensive field investigation of providers selected on the basis of deviations from established norms as determined by a quarterly review of billings submitted by all providers.

Through this review system, providers exhibiting unusual patterns of treatment and/or billing are referred for further analysis and investigation. This allows the State to concentrate its efforts on those cases which appear to most likely represent abuse or which offer the most potential for return to the State.

The Blue Cross/Blue Shield audit program, on the other hand, was a routine without cause review of providers which, because of its random nature, produced little results. In illustration of this fact, Blue Shield, in 1971, with a staff of 58, recovered slightly over $1 million. An interesting point here (all figures are from Blue Shield's 1971 annual report) is that $873,000 of this total was recovered as a result of billing errors by one hospital, meaning the balance, or some $164,000 was recovered from all other Michigan noninstitutional providers (Blue Shield at that time paid for services by noninstitutional providers). This relatively small recovery, as the result of over 3,000 audits conducted by 58 persons, casts serious doubt on the cost effectiveness of Blue Shield's audit program.

In contrast, the State's medicaid investigation unit, working with a staff of 20, in fiscal year 1974–75, made actual recoveries of $1.2 million and had additional investigations in progress with a projected recovery value of approximately $3 million.

These recoveries are made primarily from noninstitutional providers in the case of both Blue Shield and the State. As such, comparisons of recoveries to benefit payments should be made on that basis in both cases. (In fiscal year 1974–75, institutional benefits exceeded $400 million.) It is a significant distortion of data to compare Blue Shield recoveries to payments to noninstitutional providers while comparing State recoveries to total expenditures.

The issue of prepayment controls is another area which is evidently misunderstood or which has been misinterpreted. Blue Cross/Blue Shield has construed the State's projected annual saving of $20 million (an inflated saving) following implementation of a prepayment screening process for hospital bills, to imply that the system, as presently operating does not incorporate a prepayment screening process. The present system does in fact include an extensive prepayment screening process involving 167 different edits or checks, to which all claims processed are subjected during processing. The prepayment screen cited by Blue Cross/Blue Shield for hospital bills is an additional edit involving length of stay criteria and savings anticipated from this edit are in addition to those currently being accrued. Our total projected savings for the current fiscal year for edits now operating are $39.2 million. This saving does not reflect billing reductions where amounts billed exceed screens.

The administrative efficiency and effectiveness of the present Michigan medical assistance program is amply demonstrated by its performance. The line has been held on administrative costs in a period of high inflation, rapidly expanding benefits, and of increasing administrative responsibilities. The program has been subject to review by representatives of both the State and Federal governments, has passed them all with high marks, and has been cited as a national model in many areas.

I concur with Michigan Blue Cross/Blue Shield's suggestion that administrative costs and savings need to be more precisely defined in any effort to compare past and present management, and have attempted to do that in the above discussion. If there are any further questions, or documentation required, I would be pleased to respond. We are looking forward to your visit.

Sincerely,

Paul M. Allen.

[Enclosure]

MICHIGAN DEPARTMENT OF SOCIAL SERVICES—MEDICAID CLAIMS COST BY FUNCTION FOR FISCAL YEAR 1975–76

	FTE	Item (thousands)	Cost per claim
A. Paper processing:			
Document control	30.0	$1,502	$0.0484
Pended claims (MDSS)	70.0	784	.0252
Pended claims (MDPH)	9.0	152	.0049
Technical services (cod.)	30.0	388	.0125
Keytape	45.0	325	.0104
OCR	6.0	84	.0027
Hardware		1,180	.0380
EDP operations	36.0	468	.0150
Treasury Department 500,000 warrants per year at $0.04		20	.0006
Total	226.0	4,903	.1577
B. Claims direct services:			
Provider and recipient services	35.0	436	.0140
CARS (excluding C.S. & A. for MCF's and CCU's)	17.0	310	.0100
Investigation unit (excluding SNF's, ICF's, and HFA's)	33.0	506	.0163
3d-party liability (75 percent B/S–25 percent B/C)	30.0	353	.0113
Systems development (BuMIS)	28.0	447	.0144
Utilization review (MDPH–50 percent)	33.0	583	.0188
Invoice processing administration	2.0	42	.0013
MFM administration	2.0	35	.0011
Total	180.0	2,712	.0872
C. Claims indirect overhead:			
Personnel division (MDSS)		20	.0007
Accounting operations (MDSS)		44	.0014
Business services division (MDSS)		57	.0018
Total		121	.0039
D. Administration: Medical assistance bureau director and management analysis, subtotal	18.0	283	.0091
Sum of A, B, C, and D (this value comparable to Blue Cross/Blue Shield functions)	424.0	8,019	.2579
E. Additional MDSS/MDPH costs (non-BC/BS functions):			
Exception unit (MA)	8.0	179	.0057
Common audit (Blue Cross)		264	.0085
Bureau of chief and staff (MDPH)	6.0	150	.0048
Policy and planning (MDSS)	23.0	646	.0208
Policy and planning (MDPH)	5.0	134	.0043
Utilization review (MDPH–50 percent)	33.0	583	.0188
CARS (MCF's and CCU's)	17.0	310	.0100
Regulation and review (SNF's, ICF's, HFA's)	6.0	75	.0024
Investigation unit (SNF's, ICF's, HFA's)	2.0	30	.0009
PT and OT prior authorization (MDPH)	7.0	102	.0032
Dental prior authorization (MDPH)	33.0	735	.0237
Nursing home rate setting (MDPH)	20.0	371	.0119
Subtotal	160.0	3,579	.1150
Grand total claims processing costs (sum of A, B, C, D, and E)		11,598	.3729
F. Other public health title 19 costs/nonclaims processing:			
Medical review and nursing home evaluation	11.0	520	
EPSDT	25.0	4,666	
Maternal infant care		53	
Medical care and treatment crippled children		514	
Delineation and scope of services		51	
Licensing and certification		946	
Utilization review (hospital plans)		106	
Concurrent review	7.5	147	
Total nonclaims processing cost		7,003	

CLAIMS PROCESSING COSTS, FISCAL YEAR 1975–76

	Total	Cost per claim
Blue Cross/Blue Shield comparable fns	$8,019,000	$0.2579
DP costs included	(2,504,000)	[1] (.0805)
Added MDSS/MDPH fns	3,579,000	.1150
Total	11,598,000	.3729

[1] 31 percent.

NOTES

A. Based on 31,000,000 claims fiscal year 1975–1976.
B. Costs projected from expenditures through February 1976 plus estimated encumbrances.
C. MDPH costs left at budgeted level. This overstates BC/BS fns. only slightly (only 2.3 cents included fm DPH there) but increase non-BC/BS substantially more.

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